R.N.

a journal for nurses

- What Has Happened to our Nurses
- Is O.R. Experience Necessary?
- The Pay-Off for Polio?

January 1954

R.N.

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January 1954

EDITORIAL Vol. 17, No. 1

Topics of The Times

Around the Clock

Nowhere is more profound joy and sadness squeezed into each twenty-four hours than in the hospital. Around the clock, day after day, in every general hospital of the city the balance wheel continues on its interminable path. Children are born, men and women die, suffering is eased, pain is ended. While the city sleeps or bustles unconcernedly about its business, drama unfolds in the wards, in the operating rooms, in the waiting rooms, in the ambulances. Even as this is being read, surgeons somewhere in the city are putting to use thousands of years of study in an effort to save a life. Near by, friends and relatives are suffering the anguish of doubt. A participant of the drama of the hospital and at the same time a spectator to the emotional scene is the nurse, apostle of Florence Nightingale, the Lady With the Lamp.

Role of the Nurse

To many patients the nurse is the tormentor who awakens him while even the sun still sleeps; the woman who uses him as a human pin cushion, or so it seems, with hypodermic needles. She scolds him for not eating, she chides him for trying to avoid his medicine, she admonishes him for getting out of bed against orders. But she also comforts the patient in his suffering, feeds him if he cannot feed himself and ministers to his needs day and night. Hers is a task that requires deep understanding, astute diplomacy and the ability to absorb the barbs of daily association with pain and death. Nearly a hundred years have passed since Miss Nightingale organized a band of volunteer nurses to go to the Crimea, where they worked in the hospitals during the war there, but this spirit of devotion still lives. And with the ranks of nurses dwindling in the face of their increasing necessity, the measure of individual devotion takes on greater importance.

Not Easy Life

The white cap of the registered nurse is not easily obtained. Long days of hard, disagreeable work with few liberties comprise the early months of training and a rigid routine continues for the following years of study. Those who do not find the way too difficult learn to assist at operations and master practical nursing, massage, dietetics, bacteriology, physiology and anatomy. The graduates take devious paths, some into private nursing, some into positions as airline stewardesses and others into school or industrial nursing, but among the more heroic under existing conditions are those who take up the burden of hospital work, particularly in the city-owned institutions. Coping with the many and varied problems that arise in the city hospitals puts the nurse through an emotional wringer daily.

In the City Hospitals

The nurse in the city hospital receives a monthly wage of $240, a sum that many secretaries may not find unusually appealing. She gets no night differential as does her sister in white at most private institutions. In at least one large city hospital, for instance, it is not unusual for only one registered nurse to be on duty throughout the night. There are internes and medical assistants on hand, of course, but certain tasks are to be performed by the nurse alone. She finds herself rushing hither and yon to meet the various emergencies that arise and must indeed be dedicated to her calling to carry on under such pressure.

Rewards of Work

The compensations of the job transcend monetary considerations. While it may be true that some young women turn to nursing because of the glamour of the immaculate white uniform and the Hollywood-inspired opportunity to call Dr. Kildare, the great majority of them enter the profession with a sincere desire to help suffering humanity. So profound is this feeling that many forego the opportunities of marriage and others continue on the job even after taking on the responsibilities of family life. The accomplishments of nurses in modern warfare also have provided a brilliant page in medical history and even now new chapters are being written by their deeds in Korea. The Lady With the Lamp must be very proud of all of them.

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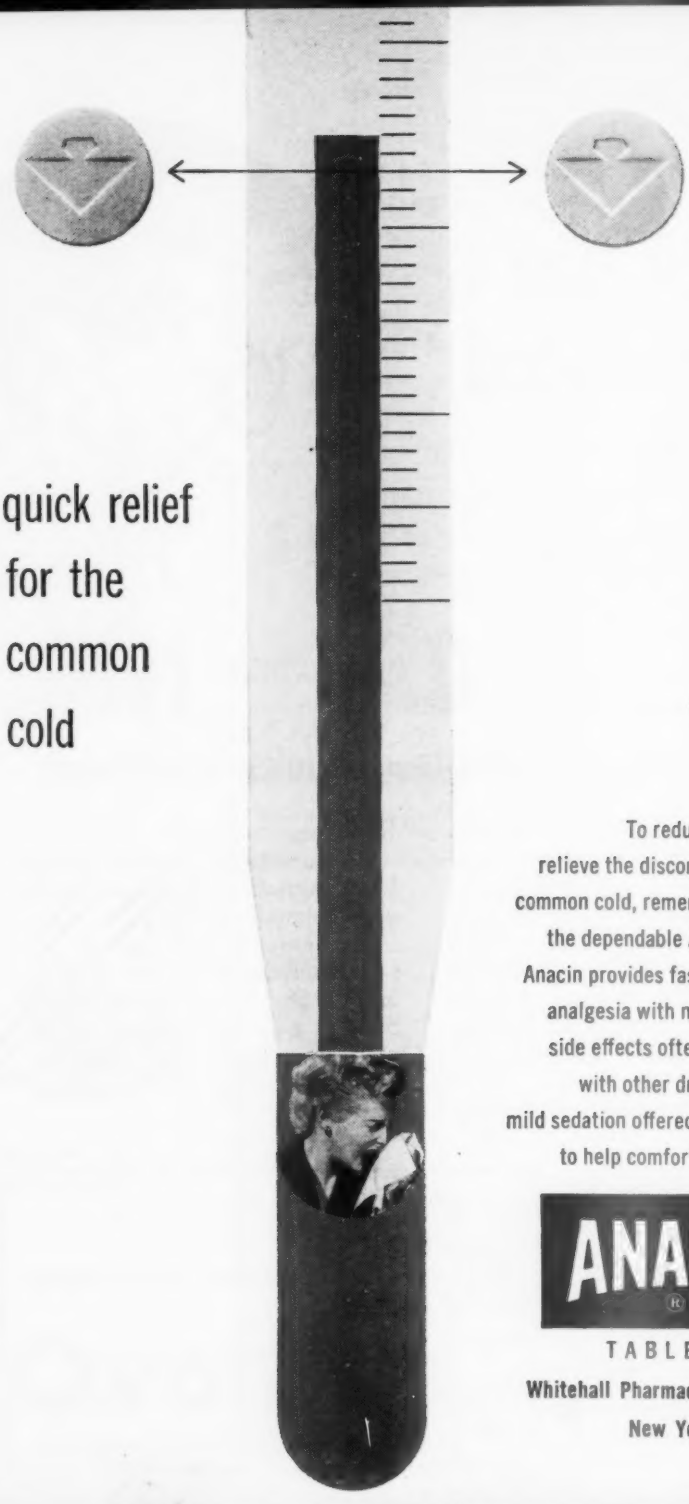

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Alas, Too True!

Dear Editor:

Your editorial in the October issue is especially appreciated by me, as I returned recently from a seventeen-day stay in a leading hospital of this city. When I think of my three years in training at the University of Pennsylvania Hospital and compare it with what I observed, I recommend that you continue to expose the pretense made by many that they are real nurses. I believe every word you wrote is true, and can be multiplied many times. More power to you!

EDITH CHAFFEE, R.N.
LOS ANGELES, CALIF.

* * *

I am enclosing one dollar for my renewal of **R.N.**—can't do without it. It gets better all the time. I especially enjoyed the editorial in the October issue. It was along my line of thinking. It does not make any difference how many degrees we have, if we fail to have that human touch.

MRS. W. A. FICKLING, R.N.
BLACKVILLE, S.C.

* * *

I am very sorry to say that I have just experienced almost everything your October editorial mentioned during my recent illness. I had heard of this sort of treatment but always thought it was exaggerated. I now know that it does take place. During my hospitalization, in a large hospital here in Massachusetts, a few of the nurses were real, but the night nurse was the worst I have ever met. I had a severe pain and was unable to turn and stay on my side. For four days I stayed in one position, on my back. The only time I was turned was during morning care. Not one nurse asked me where my pain was, how severe it was, or why I was admitted. They couldn't even take time to say "Good morning." The doctors were wonderful to me, so were the little maid who polished the furniture, the volunteer worker, and the maid who at times brought my tray.

R.N., WESTFIELD, MASS.

[*See this month's editorial and Miss Geister's* Candid Comments.—THE EDITORS]

Stop Poor Care

Dear Editor:

As a new subscriber to **R.N.**, may I take this opportunity to express my feelings about nursing in general today? In your September issue, you mention membership in organizations, and "facing whatever facts are revealed with honesty and vigor."

If nursing organizations are *for* nurses, would they not do a great

deal more for the profession as a whole not only by raising nurses' salaries but also by public education as to their duties. Our nursing organizations have not told the public what a good nurse is, and apparently have no intention of doing so.

Granted that in any hospital there are probably good and bad nurses—but why in the past few years do there seem to be so many more bad ones—and why can't our national and state nursing organizations check more closely on this matter—find out how patients are treated by nurses, and act accordingly, even if it means suspending a few licenses? I believe it is coming to a point where a stiff penalty is the only thing that will awaken some nurses, and if our associations are really for the advancement of nursing let them take some action to see that nursing itself sticks to its primary purpose—the patient's welfare.

I feel it would be well worth the expenditure for the ANA to: set up standards of nursing care—from the patient's viewpoint; publicize these standards through the doctors, who could distribute them to each patient hospitalized; encourage patients to send in anonymous complaints if they feel the standards are violated; and then let the profession's spokesmen investigate these complaints, submit a frank report to the heads of the nursing departments, and try to work out some provision for removing a hospital's accreditation if its standards of nursing service are low.

You may think me over-emphatic, but I believe the situation is really bad. I have known of a patient, both arms tied to her sides, left without mouthwash or an offer to help her brush her teeth for two days, until her roommate could get up and help her—and the patient was afraid to ask a nurse to do it for her because, "They were all so busy, poor girls." That is not real nursing—but it is what passes for it today.

LOUISE B. QUINN, R.N.
EVANSTON, ILL.

"The Nurse and Tips"

Dear Editor:

Orchids and orange blossoms to Evelyn T. Pastore for "The Nurse and Tips" [**R.N.**, November, 1953]. Several years ago, I sent a letter to the *Missouri Nurse* concerning the nurse with her hand out and palm up. The gracious editor printed it, and what happened? My calls for duty dropped to zero and I was given the old brush off by every nurse I chanced to meet. One nurse accused me of taking much needed fresh fruit from her children—a luxury her low salary did not provide.

R.N., ST. PETERSBURG, FLA.

* * *

In all the years I have been an interested reader of **R.N.**, I have never experienced the feeling of fury and disgust which the article relative to the nurse and tips aroused. Does one tip one's doctor, dentist, lawyer? Then why refer to an occasional present from an appreciative patient as a "tip"? To me, tips belong in the province of the waiter, the bootblack, the taxi driver, the maid, etc., and

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not to the registered professional nurse. In my career as a private duty nurse, a staff nurse, and a charge nurse, I have been the recipient of presents, sometimes money or a check, sometimes something personal, but I can assure you that it was neither given nor received with any other feeling than that of appreciation from the patient to me.

If by any chance there may be one or two in the profession who seem to have their hand out in advance, more shame to them. If this is the result of all the fine-sounding talk about degrees, raising of standards, advancement of the profession, I could wish the clock turned back twenty years or so, to the days when the patient was of prime importance. I can number among my closest friends today patients and their families whom I cared for ten, fifteen, and even twenty years ago. Would "tips" or my hand out have brought about that result? I don't think so.

NAN T. CUMING, R.N.
NEW YORK, N.Y.

* * *

When our nursing staff read Albert Q. Maisel's article, "What Has Happened to Our Nurses?", we were incensed, and we protested its publication in a letter to the editor of the newspaper supplement which carried it. When I read, two days later, the article on tipping in the November **R.N.**, I felt thoroughly confused. What has happened to our nursing profession? Can it be possible that nurses feel their salaries are so inadequate that they must resort to tips? If so, our hospitals should certainly take stock of themselves and see that nurses are paid enough so they do not have to have their salary subsidized by the patient.

I know that nurses' salaries aren't the highest, and I also know the nurse's attitude many times is, "It is all well and good to talk about the satisfaction of helping a patient, but a nurse must eat." But outstanding salaries in any field are in the minority, and I am sure there are nurses in some positions earning as much as the high salaried office worker. Anyone who applies himself and works can get ahead today no matter what field might be chosen. Any nurse who specializes in a field of nursing other than general duty is much in demand and is offered a salary equal to any other profession. If a nurse is willing to work, she is able to collect for what she does. It is usually those who make no effort to improve their service who complain about what a poor deal the nurse gets. I still have faith in our nurses and I know that in any emergency they will more than fulfill the pledge they take as a nurse. I feel they are being misrepresented by a minority, which is unfortunate. We have a worthy profession to be proud of, and we should all unite to defend it.

(MRS.) GERTRUDE OLSEN, R.N.
SHEBOYGAN, WIS.

* * *

That article on tipping is about the most shocking revelation that has come to mind in a good many years of nursing! At first I was inclined to believe that patients were confusing nurses with aides and attendants, but

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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery. 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

a little personal research revealed that it didn't matter which they talked about, they were likely to be right. But all the folks here who knew about it say it seems to be regional, and I don't believe it is widespread down here.

While I do believe this is an issue on which every nurse should stand up and be counted, let me first say that it is also an issue on which it would take the wisdom of Solomon to know what is tipping and what is not, in some cases. I don't believe in an outright condemnation of gifts of appreciation sent to nurses at the end of their cases, especially if they are just that. Moreover, no matter how conscientious a nurse is, there comes a time when it is either "hurt or be hurt." To snub a patient's gift could put him in the wrong when his intentions were well meant. But to accept money for services not yet rendered definitely subverts our professional dignity. Whether we accept a "tip" or a "gift" can make a big difference in our self-respect. The self-justification, or attempted self-justification, that if "hospitals would pay us enough this wouldn't be necessary," is evidence enough that nurses who do accept "tips" feel rotten about it. Fine! As long as they feel it is beneath them, there is hope!

(Mrs.) Flora Murray, R.N.
San Antonio, Tex.

Reactions

Dear Editor:

The article "Our Professional Free Lancers" was the worst slap I've ever had. I not only feel hurt but insulted. I am a private duty nurse. I also have very gratifying letters to show that private duty nursing saved many a life in the past and I believe it will continue to do so.

Margaret Reed, R.N.
Chicago, Ill.

* * *

I am writing this letter for two reasons. First, I want to renew my subscription to your magazine and express my appreciation for the help and inspiration it is to me. Second, I'd like to protest against some of the remarks about private duty nurses in the October issue. There are a few private duty nurses left who strive to give good, conscientious nursing care. We who try to be good nurses resent those who are careless, who sleep while on duty, and who make general nuisances of themselves as much as anyone else does. Yes, the standards should be raised, but if the time should ever come when private duty nurses are employed by the hospital rather than working through an Official Nursing Bureau, I will quit. I prefer to be independent.

R.N., Arlington, Tex.

* * *

I read "Prognosis for Private Duty" in the October issue with increasing indignation. Private duty nursing will not only continue but will flourish, since the private duty nurse is the only defense patients have against the poorly staffed hospitals with little or no nursing care to offer them. In their efforts to subdue and humble the proud and in-

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dependent private duty nurse, the authors have neglected to compare standards of nurses in other fields, which, I am sure, on the average are about the same. As for socialized nursing, which is exactly what they suggest, I do not see that as the answer to the distribution of nurses any more than socialized medicine has been the answer to the medical problem. Regimentation has never been and never will become part of the American way of life!

ROSALIE HAZEN, R.N.
MIAMI, FLA.

* * *

R.N. has been very helpful to me, and is getting better all the time. The October issue was particularly helpful, especially the panel discussion on private duty nursing. Thank you very much.

NELLIE M. HUNTER, R.N.
SHENANDOAH, IOWA

* * *

Your symposium on private duty was a slap in the face and I humbly turn the other cheek (after I get a few things off my chest)! I won't pick the gripes apart, as it would take up too much time and space, but Miss Geister summed it up for the profession (private duty included) when she wrote, "The techniques and medications are new and changing but the fundamentals are permanent—the understanding of people, the knowledge of how to protect and comfort and help them, the ability to evaluate symptoms. Faith in our profession, our fellowmen, in God." A brush-up period is sometimes all that is needed for one

If your patient has a "?" about coffee–

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of the profession coming back, whether she does staff, private, or office nursing. A little guidance from a younger nurse, a doctor, and a lot of reading on the new medications sometimes helps the older nurse over the initial period. We may be in her shoes some day.

ROSE DI ORIO, R.N.
GEORGETOWN, CONN.

* * *

As I am a very busy registered nurse, with none of the bad qualifications the authors of the symposium on private duty spoke of in their articles, I will try to answer them. I regret those articles.

My intellectual friends, I can't understand your remarks. Here in New Jersey, instead of criticizing, we try to help one another. Don't be so hard on the poor private duty nurses, as there are many mistakes made by many who have numerous degrees, I know.

Do you know much about malpractice insurance? I would ask you to speak to a lawyer about group nursing.

Don't worry, with ANA support and our membership increased, maybe the poor private duty nurse may surprise you. Are you really private duty nurses, or disgruntled supervisors? I have always liked **R.N.**, but now I question the editors' views. The book certainly is no help to us.

JANE F. KELLY, R.N.
NEPTUNE, N.J.

[*There is no question but that we have put our fingers on the sorest spots in nursing.*—THE EDITORS]

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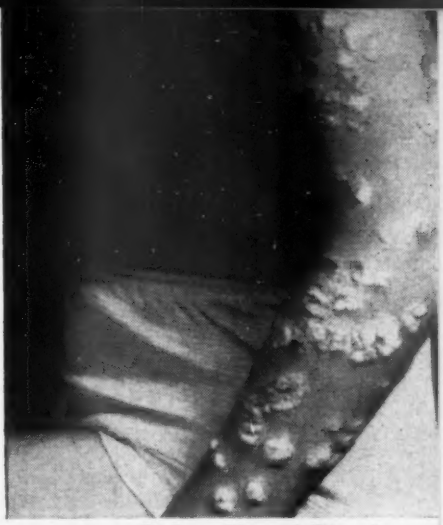

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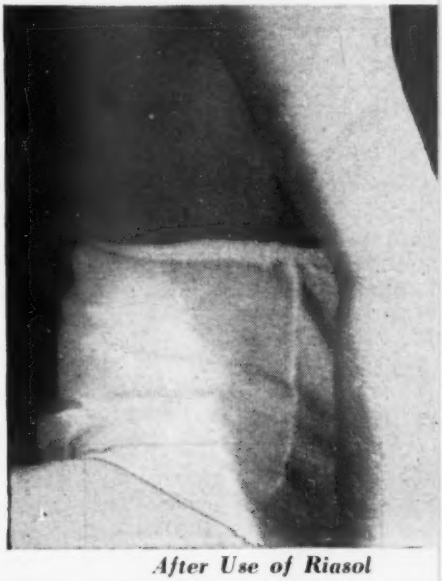

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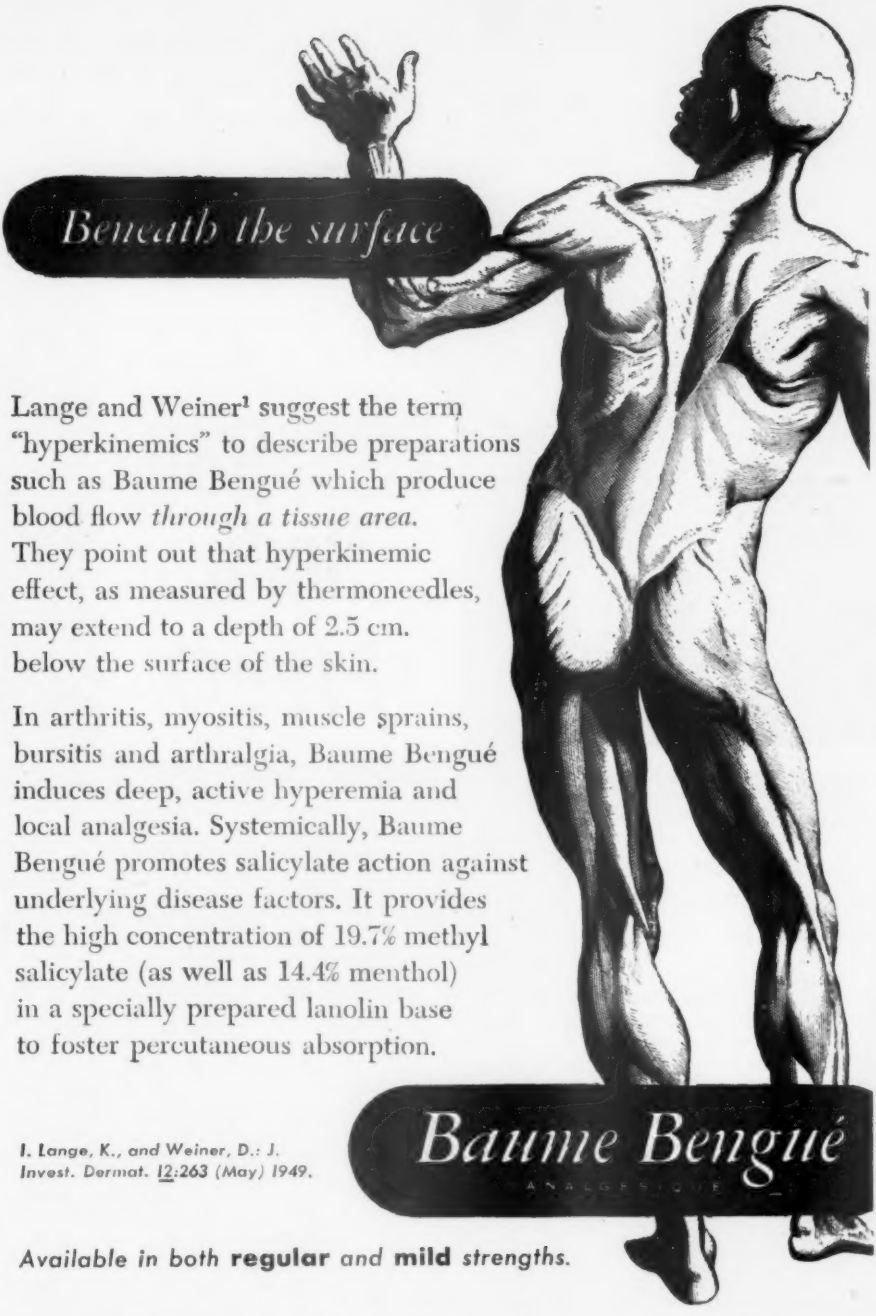
*Study conducted at The Hahnemann Medical College and Hospital of Philadelphia.

**Fischer, C. C.: Clinical Study of Skin Rashes during the Newborn Period, AM. J. Dis. Child. 85: 688-693, 1953.



Lange and Weiner[1] suggest the term "hyperkinemics" to describe preparations such as Baume Bengué which produce blood flow *through a tissue area.* They point out that hyperkinemic effect, as measured by thermoneedles, may extend to a depth of 2.5 cm. below the surface of the skin.

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1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

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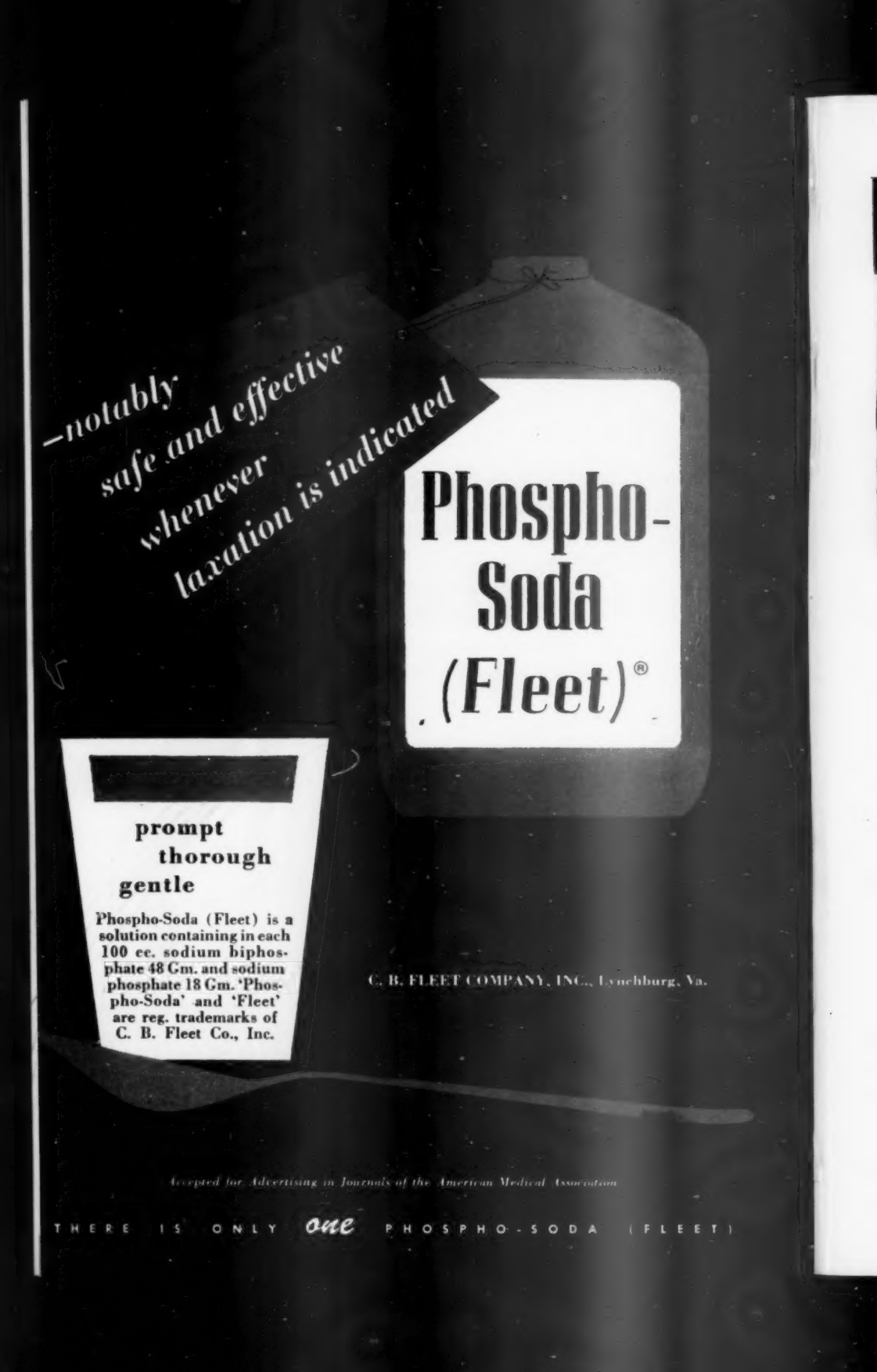
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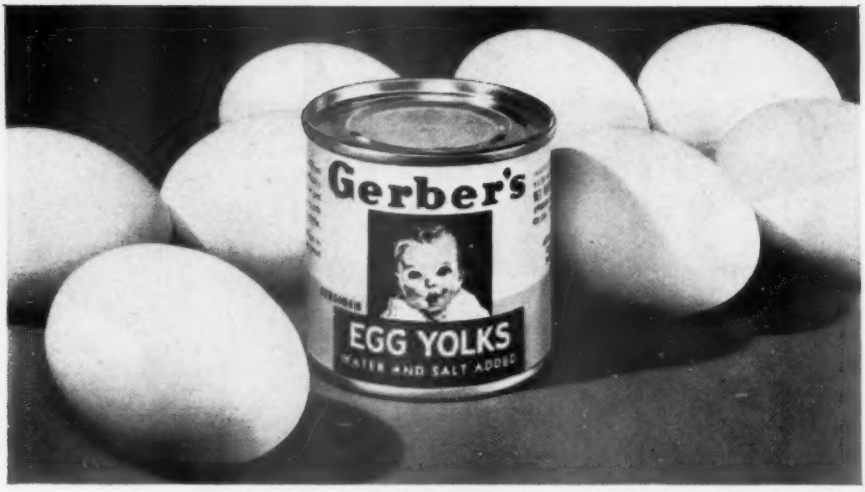

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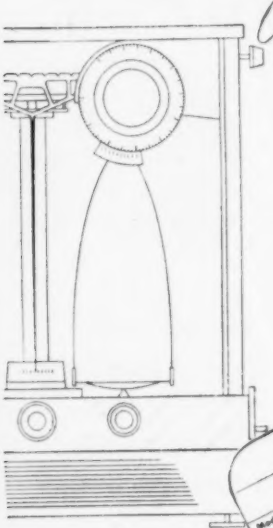

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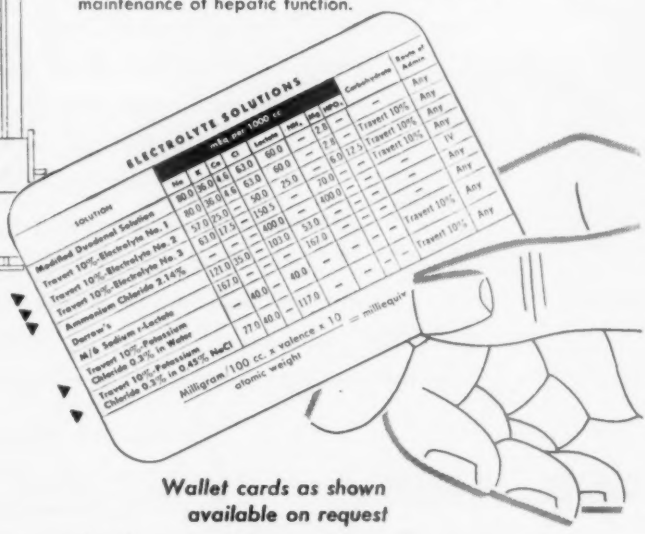

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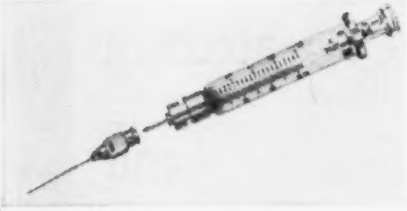

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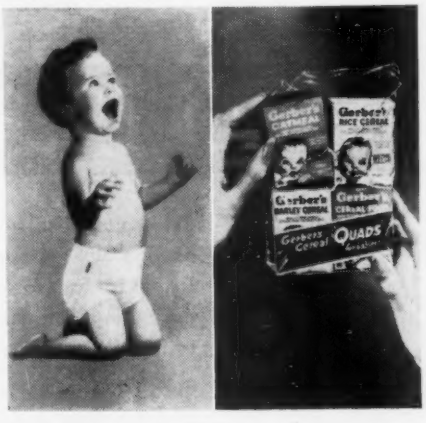

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1. Klarmann, E. G., Wright, E. S., and Shternov, V. A.: Applied Microbiology 1:19 Jan., 1953.
2. Smith, C. A.: Soap and Sanitary Chemicals 27:130 Sept., 145 Oct., 1951.

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Is it Nursing that's in Need of Reform?

■ IT IS A RARE occasion when an editor expresses regret that so many are in agreement with an editorial point of view. "Mea Maxima Culpa," which pointed out the reprehensible state of much of our present-day nursing care, elicited just such a response.

This whole problem is a many-sided one, for poor nursing care has come about as a result of many things—some of them outside the province and beyond the control of nurses. But whatever the cause, the effect—poor patient care—is something which must not continue unchecked.

The October editorial was written—not to scold or belittle the superb care so many nurses still manage to give despite shortages and questionable working conditions—but to try to point out the gravity of the situation, and to urge nurses, who give good care and know what it should consist of, to be more determined to speak out for what they believe. And in light of events since the publication of that editorial, the time to speak out is now if ever—and with all the courage of a conviction of what is right for patients and for those who are morally and legally responsible for their care.

The recent "shocker," Albert Q. Maisel's syndicated Sunday feature articles, in which he takes this problem of poor nursing care to the public, can be a boon or a boomerang to the nursing profession. It is up to us to make it a boon—an answer to our request for help.

While emotions are high in both the hospital and nursing fields is the time to make and push vigorously plans for upgrading nursing service. In too many states the committees for the improvement of patient care are paper committees only. If "sensational" articles such as Maisel's can breathe some life and sincere purpose into these committees, confidence in hospitals and nurses could be restored in short order. Such reforms need joint effort, critical evaluation of patient care and, regardless of hospital and nursing personnel shortages, some well-earned dismissals.

As from the seed comes the fruit, so from the erroneous attitudes that anyone is better than no one at all, do we now harvest the small but destructive crop of incompetents.

We nurses have enjoyed a favorable press so long as the public has been sympathetic to our cause—and so long as the public looked

upon the nursing profession as the underdog in its justified strivings for new recruits and economic security for those in the profession. But when the underdog becomes the unprotected patient—beware!

A public indictment of the nursing profession was bound to come. Complaints from patients have become too numerous and too frequent to be written off as due to the hyperirritability of the sick. But by Maisel's expose, nursing is in danger of losing the support of a most valuable ally—public sentiment—when it loses the sympathies of the press.

Mr. Maisel's articles will be only the first in a series unless the trend is redirected. Charges of "incompetence," "tip-seeking," "negligence," and "malpractice" are unfortunately based on incidents which can't be ignored even if we are shocked by them. And we cannot salve our collective conscience with the rationalization that Mr. Maisel lumps all nursing personnel together. To patients—professional or non-professional—they are all nurses. Our professional organizations in desperation have encouraged the development of non-professional assistance at the bedside, while being fully aware that hospital administrators, in many instances, have been exploiting patients by the misuse of such personnel. Are we not, then, guilty before our communities of countenancing inadequate patient care? And are not members of hospital boards, who come from the communities, more guilty for their lack of knowledge and or understanding of nursing service problems?

We make a plea to nurses to read Mr. Maisel's attack and others which might follow with an open mind. And use such articles constructively—for they can provide the "real" nurses of this country with two most potent weapons—public opinion and a crusading press. With these two behind the cause of good patient care at any price, hospital administrators and boards of directors might finally be forced to recognize that it is more than a bed in a hospital that is implied in "hospitalization." More important for the patient's recovery is *professional* nursing care—*given* by adequately salaried nurses imbued with a professional attitude with *assistance* from the auxiliary hospital personnel.

—Alice R. Clarke, R.N., Editor

Reorganizational Trials and Trends

The rigors of the straw-hat circuit of show business are nothing compared to the convention circuit of the state nurses associations which begins in September and ends—almost everyone who rides it.

Markedly affected by their experiences of dodging hotel waiters' trays, of partaking of too many anniversary cakes, and firmly convinced that there is a diabolical plot among hotel microphones to unnerve all convention speakers, the members of **R.N.***'s staff checked in after over four thousand miles of travel to pool their impressions of what they found to be the organizational trends in the various states visited.*

■ ORGANIZATION—or, in some cases, disorganization—was the keynote of meetings of both state leagues and state nurses associations as members struggled to form sections and departments according to the accepted national blueprints. The main impetus to the formation of new state sections seemed to be not so much the desire to conform to the national pattern as the realization that representation in '54's ANA House of Delegates is dependent upon section membership.

Section Formation

There were some, however, who voiced uncertainty over the changing order. In several instances, members of the Special Groups Section —the catch-all section—were confused as to their purpose and functions; and some sections, for which there is no national counterpart, refused to dissolve.

But despite the doubts expressed on the organizational value of segmenting membership into sections, there was encouraging evidence that certain pre-established sections, especially the general duty nurses section, were on the way to developing an *esprit de corps* and an awareness of the importance of their specialty. It was also evident, from the few section meetings that R.N. representatives were allowed to attend, that courses in parliamentary procedure might well be given high priority in future section projects.

Closed Section Meetings

In a number of states, section meetings were open only to section members and ANA consultants. The wisdom of this "closed door" policy is a debatable point. The degree to which the ruling was enforced during recent conventions gave the impression that sections are secret societies rather than cooperative units of a professional organization. At certain times, closed meetings may be a necessity, but why make them a general rule? Information usually leaks out of a closed meeting, anyway, and sometimes, the "facts" disclosed in this manner are far from factual. This policy is probably

based more on a poor concept of public relations than on anything else—and it backfired in at least one state where the erroneous information which reached the public was a source of embarrassment.

Section Chairmen Representation

Another doubtful privilege which

sections in several states are promoting, with the help of ANA consultants, is the inclusion of voting section chairmen on the SNA Board of Directors. The moot point here is whether a chairman elected by a small portion of the membership should make policy decisions concerning the membership at large. Certainly, however, there should be some way of presenting to members a representative list of nominees for board membership.

One-Organization Pressure

Many nurses still believe that one over-all organization would best serve their interests. Behind the scenes, as well as at official business meetings in some states, the question was repeatedly asked: Why can't we have one organization? The New York State Nurses Association, meeting in convention, even went so far as to resolve that the Board of the NYSNA "continue to explore ways and means of close cooperation with the New York State League for Nursing with the view toward having this state pioneer toward a goal of one professional organization to which all professional nurses will belong . . . "

Undoubtedly, this attitude has been brought about by the confusion in members' minds over their respective places in the local leagues and SNA's, the inability on the part of numerous nurses to pay dues to two organizations, and the struggles of both organizations, particularly the leagues, to expand their membership. One recurring argument is that there are not enough willing and qualified workers to serve two organizations. As a result, the same nurses are active in both SNA's and SLN's and are finding their dual responsibilities a drain on their time and strength.

Another contributing factor to the one-organization point of view is the weak financial position of the SLN. In some instances, the SNA's have been called upon to help underwrite the operating expenses of the local leagues. In cases where adequate funds are not forthcoming, leagues are attempting to get financial support from other sources, including

state hospital associations. Whether hospital association interest in league organization is entirely benevolent is questionable, for there is sufficient evidence in at least one state to suggest that its purpose is to build up the strength of one state organiza-

tion at the expense of the other.

Membership Losses

Membership is the big headache of the state nurses associations, as evidenced by the amount of serious and often emotional discussion on this subject at convention meetings. Some states have made gains in membership, or held their own, but on the whole, according to predictions based on membership as of August 31, 1953, membership reports for 1953 will show an appreciable loss in total membership. More discouraging still is the knowledge that no state has come within reach of its potential membership. This apathy may be due to the general increase in dues, a lack of activity on the state or district level, or to the type of membership campaigns. There still seems to be a tendency on the part of SNA's to scold non-members for their lack of professional responsibility rather than to get to the root of the trouble and analyze just why non-members don't belong or why they have dropped their membership.

Re-districting Movement

One partial answer to the membership problem may lie in re-districting, a project that some states have adopted or are considering. Because of population shifts, changes in methods of transportation, and the location of hospitals and medical centers, many of the present district boundaries are outmoded. The main reason advanced for re-districting is that many nurses would belong to the district association if its headquarters, or meeting places, were easily accessible. The largest state nurses association, Pennsylvania, has already started to divide the state into smaller districts on a county basis.

Death of a Division

Another organizational trend concerns the future of the two remaining regional divisions. Although outside of the ANA structure, the New England and Southern Divisions have been quite active in the past as forums on regional problems. The Southern Division continues to hold a favored place in the hearts of its members but the New England states show signs of cooling ardor. The Massachusetts SNA has already voted to withdraw from the New England Division, while Connecticut expects to consider withdrawal next year. Some of the factors influencing this decision are the organizational difficulties of belonging and paying dues to another organization; the ANA's discouragement of such extra-organizational regional forums; and the possible overlapping of division activities with those of SNA's. There are those, too, who believe that the time and expense involved in planning for division meetings are out of all proportion to the benefits derived.

Economic Security

Economic security was again one of the top problems at most SNA meetings. While practically every state recognized the need for some sort of an economic security program, there were some states which held out for programs with greater flexibility than that offered by the ANA plan. The general attitude, in

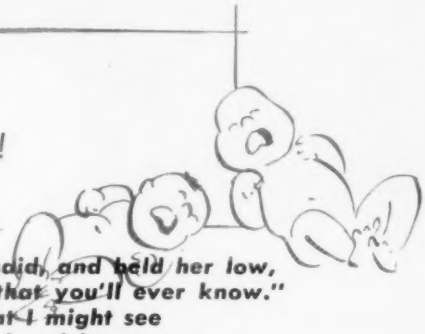
those states that **R.N.** visited, toward the ANA Economic Security Program ranged from lukewarm in Massachusetts to enthusiastic in Pennsylvania. In New York, where there has been controversy before over the adoption of such a program, the topic did not even come up for discussion. In New Jersey, after a pro and con discussion of the program, members unanimously voted to continue their own type of program, which encourages cooperation between the SNA and the state hospital association.

Rising Dues

Without one protest—almost unprecedented in state meetings—New Jersey nurses also voted to increase dues to take care of rising costs and expanded programs. Pennsylvania, on the other hand, failed to get the dues increase advocated for program expansion and spiraling costs. But finally, by some peculiar twist in economic logic, PSNA members who had fought with some vigor against a $4 increase, voted an increase of a dollar less than was proposed without demur.

The voting in of ambitious programs without being willing to pay the costs was evident during other state conventions such as those in Kentucky and Indiana. The Indiana membership [*Continued on page* 66]

We Wanted a Boy!

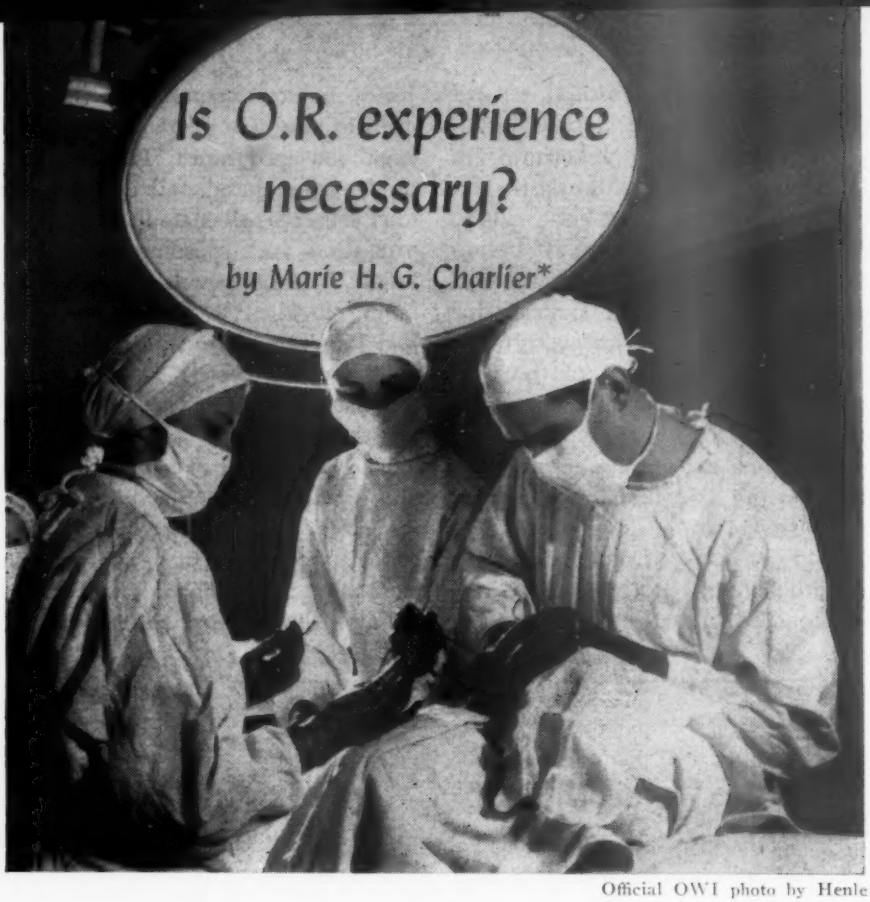


"Here she is," they said, and held her low,
"The loveliest babe that you'll ever know."
I turned my head that I might see
The new-born baby placed by me.
I was weary and spent—my spirits were low,
I had done my best, but, well . . . you know,
We'd wanted a boy—and she wasn't.

I listlessly looked; she was very fair
And plump; so small—I touched her hair.
Such tiny hands, a wee, pug nose—
And then, as though she knew my woes,
Two deep blue eyes were opened wide,
So like the eyes of my love! I sighed,
"Did we want a boy?" My heart denied.

I drew her close. I was quite sure then
We'd been all wrong—we'd always been—
In wanting a boy!

Verna Clay Harmon, R.N.



Official OWI photo by Henle

Should operating room experience be eliminated from the educational curriculum?

■ ONE HAS ONLY to compare the nursing curriculum of today with that of twenty-five years ago to know that nursing education has taken tremendous strides in preparing students for the practice of nursing. Yet the trend in nursing education to decry the value of the surgical nursing experience in the student nurse's basic curriculum should be critically reflected upon before it gains momentum. Already, some schools experimenting with curriculum changes have shortened or eliminated the student nurse's traditional experience in the surgical theater.

What motivates this change in educators' attitudes toward surgical nursing?

The idea was first advanced that the student's time in surgery was of little or no significance since it did not cover an adequate amount of surgical work. Actually, this reputedly "inadequate amount of work and

*R.N., Ph.D., on Rutgers University faculty.

time" consisted of two months, during which the student nurse had to assist in twenty-five major surgical cases and fifty minor cases. Furthermore, the proponents of the change argue that the student's apprenticeship in surgery unnecessarily and unwarrantedly taxed the energy and patience of the surgical teams. Many students, it was asserted, "were fearful of the 'holier than thou' attitude fostered in surgical groups." However, one of the main arguments for the elimination of this experience is that surgical nursing is a specialty which can be learned, if necessary, or if desired, after graduation.

Having served as a surgical supervisor for a number of years in general hospitals—both civilian and military—I am adamant against the shortening or elimination of the student's assignment to surgery. After painstakingly weighing the pros and cons, there is no doubt in my mind that the general adoption of this curriculum change would be a most unfortunate development for nursing and this country.

The elimination of this phase of the nurse's education would necessarily deny us the opportunity of detecting and encouraging potential operating room nursing personnel. Without the inclusion of O.R. nursing in the curriculum, how could we discover within the student body the skills and aptitudes that characterize the neophyte surgical nurse? If we are dependent upon the development of interest after graduation, could not the lack of O.R. experience tend to give the student and graduate a psychological block when they consider O.R. nursing as a specialty? Those who have tried to recruit nurses for TB, psychiatric, and polio nursing can testify to the psychological block encountered here—and this is basically because of fear grown out of a lack of knowledge of the specialty.

I maintain that students need surgical assignment for these additional reasons:

▶ They should understand the "why" of the special care required for different surgical patients.

▶ The two months of intensive work and association with operating room personnel does encourage informal talks on the "cases of the day" and thereby advances the knowledge of the student.

▶ The student nurse will by demonstrations and exercises learn lessons in surgical asepsis that no other hospital assignment could teach as clearly. The value of the method of learning while actually performing cannot be denied.

▶ In addition to assimilating the principles of surgical asepsis, the student will receive lessons in applied anatomy and physiology. From these lessons the student should develop a respect for the body and the body tissues.

▶ Finally, these studies in the surgical theater give the students an insight into their own capabilities and interests, help them in future work, and may arouse in them an unsuspected aptitude for surgical nursing.

Naturally, the presence of students

in the operating amphitheater does require patience on the part of the surgical staff, but the same amount of patience would be called for when postgraduates or non-nurse technicians without any experience in surgery are introduced into the O.R. To protect the patient and the staff, I believe that no student should be required to carry out completely the responsibility of a surgical technician. At all times there should be a graduate nurse supervisor present. The graduate should fulfill the role of first surgical nurse, while the student nurse should be her second—assisting and being assisted, but not eliminated.

The teaching and educational committees and staffs in institutions concerned with nursing education always stress the point that nurses perform repetitious duties that do not require skill. That is why, they say, there is a need for medical technicians (who are not R.N.'s), such as nurses' aides, practical nurses, and attendants, to eliminate the expense this needless waste of skilled personnel entails.

Starting from this premise, then, why is it not recommended by our experimentally-minded educators that the period of surgical training be extended rather than eliminated? Would not this give the student ample time to acquire surgical skills, and as a result be prepared to perform delicate and specialized tasks that are non-repetitious and truly professional in nature?

If the complete elimination of the surgical experience does come to pass, it must be borne in mind that interested graduate nurses will have to go back to school and invest in a six to twelve months' postgraduate course to decide whether or not they will enter the surgical field; disinterested graduate nurses will be willing to leave the specialty to nonprofessional technicians. Is this a future to look forward to in a country that at any moment could desperately need the surgical knowledge and skills of every available surviving nurse?

R.N.'s Subject Index for July through December 1953 is not included in this issue, as it normally would be. To avoid cutting down the space devoted to text, we are printing the index separately; in the future, it will be issued yearly. Copies may be obtained by writing to: Editorial Department, R.N.—A Journal for Nurses, Rutherford, New Jersey.

Types of Investment Securities Available

by John Y. Beaty*

[Last month Mr. Beaty discussed in a general manner various methods of investment. This month, he has elected to describe, in more detail, certain types of stocks and bonds, in preparation for his next article which will be concerned more specifically with the "when," "where," and "how" of prudent investment.—THE EDITORS]

Some bonds are *secured*; some are *unsecured*. An example of a secured bond is the mortgage bond. The mortgage bond is protected by a mortgage which is, in effect, a deed to real property of a value greater than the issue of the bonds. The deed transfers the property to the bond holder if the bonds are not paid.

Sometimes a company will issue *senior bonds* and *junior bonds*. If it is impossible to pay both types of bonds, the senior bonds must be paid first. These senior bonds are sometimes called *prior lien bonds*.

Collateral trust notes are usually classed with bonds. They are secured by a pledge of specific securities owned by the borrower —that is, in contrast to the mortgage bond which is secured by real property, collateral trust notes are secured by stocks and bonds. The collateral pledge is in the hands of a trustee.

Equipment trust certificates are commonly issued by railroads and are like bonds in form. These certificates are protected by a definite mortgage on cars and locomotives in use on the railroads.

Debenture bonds are unsecured bonds protected only by the credit of the company issuing them. Bonds issued by Federal, state, and municipal governments are commonly debenture bonds. As a rule, only companies of the very highest credit standing are able

*For twenty-four years editor of *Bankers Monthly*, recently editor of *Investor's Future*.

to sell debenture bonds to the public.

Registered bonds and *Coupon bonds* differ only in that registered bonds are registered in the owner's name and have no coupons attached to them. The coupon bond has a coupon attached for each interest payment. In the case of the registered bond, the issuer mails the interest to the owner on the date that it falls due. In the case of the coupon bond, the interest is not mailed until the coupon is sent to the issuer.

Guaranteed bonds are those the principal and interest (or only the interest) of which is guaranteed by a company other than the issuer. They are issued by some railroads which are, in turn, either leased or owned by another railroad system. The larger system usually guarantees the bonds of the smaller railroad.

Convertible bonds contain a clause which makes it possible to convert them into common stock of the company issuing the bonds if the owner so desires.

Callable bonds contain a clause which permits the issuer to call in the bonds for redemption under certain stated conditions. The price at which the bonds must be redeemed is usually included in the wording of the bond.

Income bonds are sometimes issued; they differ from other bonds in that interest is paid only if and when it is earned and declared. Obviously, it would not be wise to purchase income bonds unless they were those of the very largest and most successful companies. As a class, income bonds are a poor risk and do not make for stability of income.

Common stocks and *preferred stocks* are the two general divisions of stocks. The preferred stock issued by a company has preference in distribution of earnings over the common stock issued by the same company. In other words, if the earnings are not enough to pay dividends for both types of stock, the preferred stock gets its share first. The common stock may get less or none at all. Ordinarily, if the dividend on a preferred stock is not paid in a certain year, [*Continued on page* 78]

WOMEN AS SHAREHOLDERS

Women own:

48 per cent of all public utilities stocks and bonds

44 per cent of railroads and industrial shares

57 per cent of the stock in the DuPont Co.

56 per cent of the shares of General Motors

46 per cent of the shares of Eastman Kodak Co.

49 per cent of the shares of American Telephone & Telegraph Co.

Autograph

by James Scales

■ BETTY, a slim, pretty nurse's aide, assisted at the local V.A. hospital each evening after her day's stint as secretary in a law firm. Her winning personality, her gentle touch, and her constant attention to the needs of the patients of her ward, making them comfortable and helping them to endure smilingly their pains and afflictions, convinced them that she was something heaven sent. The vets adored her.

To their oral kudos, Betty, in her soft voice, would say, "Why fellows, I'm only doing what a nurse is supposed to do."

Such compliments pleased her because it helped them. One such compliment developed one evening that not only moved her, but became one of life's experiences to be treasured in her heart forever.

It happened one evening when the head nurse approached her as she reported for duty and said, "Betty, that young veteran in your ward that you've been taking such special care of is failing fast. Do what you can to keep his spirits up. He adores you."

Betty gave him a soothing rubdown, straightened his sheets and pillows, all the while keeping up a cheerful flow of conversation that brought a smile of gratitude from the suffering veteran. When she finished, he said, "Thanks, nurse. You've been awfully nice to me. May I have your autograph?"

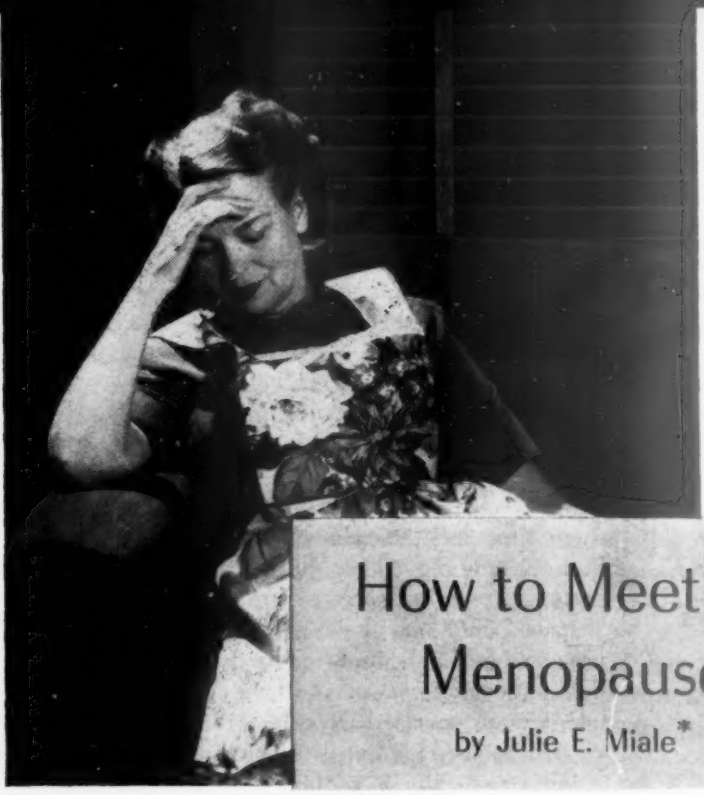
"Why, sure, soldier," smiled Betty. "But," she added, "I'm not what you'd call a celebrity. Just a nurse's aide."

The young soldier slid his hand under his pillow and withdrew a pencil and a small black book. Extending both toward her, he said, "Please, write your name in this."

Betty opened the book, paused, and in amazement said, "Why, this isn't an autograph book, soldier. This is a Bible."

A quiet smile crept over the drawn face of the young vet as he softly answered:

"Sign on the flyleaf, please. What better place is there than the Holy Bible for an angel to sign her name in?"



Ewing Galloway

How to Meet the Menopause

by Julie E. Miale*

■ LADIES, LET'S face it. If you live long enough, menopause is inevitable. Since it is inevitable, and since it is a known fact that many of the disturbing symptoms appearing at this time of life are intensified by mental excitement and nervous tension, we may as well approach it with an enlightened viewpoint and a healthy attitude.

For some women, menopause means storm and stress; for others it means new goals, new interests, and a new way of life. Like other women, nurses, despite their professional training, are often victims of superstitions and social suggestions that the menopause is clinically mysterious and pathologically dangerous. Fortunately, even in the face of this build-up of fear over the years, most women go through the menopause serenely and in good health, provided proper steps are taken to ensure their well-being.

The menopause should be looked upon as a new and necessary adjustment to the next stage in a woman's life. A seventy-year-old physician, reviewing her life, told me that the years after fifty had been happier, more interesting, and more valuable, just as the earlier years had been more intense. The oft-repeated verse of Robert Browning, "Grow old along with me, the best is yet to be —The last of life for which the first

*R.N., B.S. Free-lance author and lecturer.

was made," can well be a psychological basis for approaching some of the more common problems of the menopause.

Part of the Aging Process

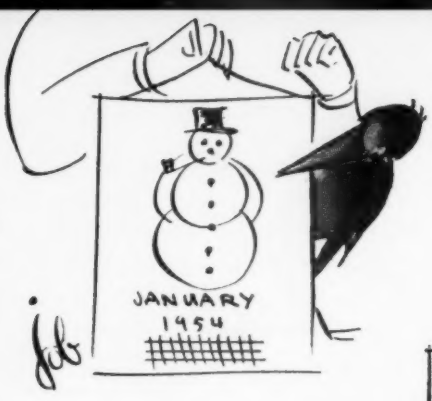
While menopause is the manifestation of aging, of a regressive physiological process, it is also a developmental phase. Anatomical observations have confirmed the importance of involutional atrophy in the aging process. This atrophy, although constant and widespread, does not affect the various organs to the same degree or at a uniform age level. In menopause, the ovary atrophies and loses weight, and there is a decline in ovarian function. Yet, apparently women vary greatly in their response to this expression of estrogen deficiency. Furthermore, estrogen deficiency does not always provoke symptoms during the menopause; nor do females with primary ovarian deficiency ever manifest symptoms referable to the menopause. It would appear, then, that other factors, as yet not understood, are at play. These factors are apparently influenced by the rapidity of the declining ovarian activity, the susceptibility of the autonomic nervous system, and the emotional stability of the individual.

What Happens and When

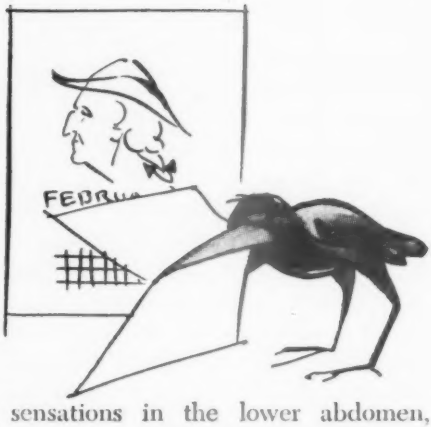
Menopause means that ovarian function ceases, either naturally or artificially. Usually, this occurs between 45-50 years of age. However, this is only an average, and there are probably many factors which influence the time of the menopause such as the general state of health, heredity, sexual life, and variation in climate.

As the aging process of the ovary sets in, the decreasing ovarian activity begins its insidious course. This wearing-out process begins several years before the cessation of the menses and continues for a time thereafter. These periods before, during, and after menopause are described as premenopausal and postmenopausal. The entire period is known as the climacteric. The signs and symptoms of each period, which vary considerably, may be grouped as follows: 1) Premenopausal: skipped periods and scanty or lessened menstrual periods, 2) Menopausal: cessation of menstruation accompanied by a variety of vasomotor, sudomotor, and central nervous system disturbances. There is some controversy as to the nervous system disturbances, for these depend a great deal upon the general make-up of the individual. 3) Postmenopausal: These years are characterized by good health and assurance and more stability of thought and action in the normal woman. The severity, mildness, or complete absence of symptomology apparently depends upon the withdrawal of the ovarian hormone. This deduction is supported by the fact that abrupt cessation of ovarian activity brought about by castration in the adult woman is usually followed by severe withdrawal symptoms.

In the normal course of events, the menopausal changes evolve as a gradual process rather than a sudden upheaval. The well-adjusted



"Zeke & Dessie"



woman is aware of the changes taking place, but finds little cause for alarm. The less fortunate ones, however, go through a period of from two to four years or more, when discomfort and uncertainty regarding their health can play havoc with their daily lives. Because many of the complaints during this period are relatively minor, many women, including nurses, postpone a visit to their family physician at a time when they need advice and guidance the most. There is a tendency among women and doctors, too, to blame the menopause for conditions which at another time would be considered alarming. Suspicious signs and symptoms should be reported promptly so that adequate steps may be taken toward proper diagnosis and treatment.

Some of the symptoms which deserve prompt reporting include any abnormal vaginal discharge, spotting between periods, excessive or too frequent periods, and periods that last too long. Unusual irritation or ulceration of the genitals should also be reported. If there are urinary or bowel disturbances, abdominal pain, distention or swelling, bearing down sensations in the lower abdomen, protrusion of the cervix or continued backache, these should be called to the physician's attention.

Need for Reassurance

Most women, although they have no symptoms that warrant complaint, are in dire need of reassurance as they approach the menopausal age. The basis of much of the psychoneurotic type of complaint can be based on the unspoken fear of old age. Since the majority of women sincerely want to approach this period of their lives gracefully, they need help and medical assurance through expert physical examination, with attention to the preventive aspects of medicine.

Choice of Physician

It seems a shame, but nurses know only too well, that after a

cursory examination and a very brief history, too many physicians say "it's just your menopause," give the patient a hormone shot, and send her away to figure out for herself—or through neighbors and friends—what it is that troubles her. These are the same physicians who refer to women's ailments as a "pain in the neck," and consider them outside their practice. Unfortunately, however, they *do* consider them *inside* their practice range. Is anything accomplished by this type of doctor? Absolutely nothing. Stay away from him, or you will go away from his office extremely dissatisfied.

For nurses, as for other women, a gynecological examination, treatment, or operation, more often than

not, carries emotional meaning. The female biologic and psychologic drives, the superstitions, and prejudices emerge at these times. An opportunity to talk with an uncritical and interested physician is of the greatest therapeutic value. Despite the fact that most physicians have little or no formal training in psychiatry, they often exhibit an uncanny faculty for sensing emotional involvement. A physician who has patience and sympathy, who can lead the patient on to an appraisal of her feelings, is the kind of physician to choose. He is the one who is able to gain insight into the patient's physical, emotional, and sexual life with little effort, thus establishing a history which will prove to be a sound foundation for optimal treatment.

Cooperation

Every nurse knows the value of a good history in helping to make a diagnosis and institute the proper treatment. The problems surrounding the menopause are so complex and varied that the physician must be assured of the patient's complete cooperation and honesty in giving him facts about her life, otherwise, she will not receive the maximum benefit from his professional service. She should be prepared to give a chronological history of the events in her physical, sexual, and emotional life, which, in her estimation, will be helpful in the management

of her case. This information should be as brief as possible, and free of long drawn-out irrelevant data. She must be willing to pull out all the stop signs in answering questions. These questions may seem unimportant to her, or they may be so personal in nature that she may mistakenly place the wrong interpretation on the need for inquiry into a certain phase of her history and become frightened or resentful.

Physical Examination

A thorough physical examination should be insisted upon even though the physician says one isn't needed, or feels the expense and time involved is a hindrance. This is sometimes the case when problems regarding professional courtesies enter in. Many doctors feel that medical care to a nurse or fellow physician should be given out of courtesy. This is all very well but it can be carried to the point where it hinders the patient's welfare. A nurse shouldn't hesitate to ask the doctor any questions that trouble her, and to express her willingness to pay for the kind of physical examination, diagnosis, and treatment she needs at this time.

Since cancer is first and foremost in the minds of many women, cancer should be definitely ruled out. Usually, an examination for this purpose may include palpation, inspection, smears, biopsy, x-rays as well as other tests which the doctor may feel are necessary. In many instances, before definitive treatment for the menopausal state is started, laboratory procedures such as urinary and hormonal assays may be necessary.

During the examination, the blood pressure should be taken, followed by advice and reassurance. The habits of life should be discussed generally and some thought given toward adjustments for a happy and useful aging. Sound measures of general hygiene may be prescribed with special attention to such dietary difficulties as obesity, malnutrition, and vitamin deficiency. Not to be overlooked, also, is the clearing up of troublesome sexual problems.

Therapy

There is a wide range of menopausal treatments available to the physician. A large majority of women who experience distressing symptoms of the menopause are in need of replacement therapy. This type of therapy, which simulates the patient's slowly aging ovary, substitutes for the lack of the patient's own estrogen. By letting her down *gradually* in this period of change, it temporarily removes the cause of symptoms. Those who suffer from menopausal symptoms are entitled to the gratifying relief derived from a carefuly selected and highly individualized program of endocrine therapy. Careful and frequent follow-ups, including laboratory and other examinations, are most essential during the early treatment period.

The need for replacement therapy, the dosage, and the methods of administration will depend upon the physician's appraisal of the patient's actual [*Continued on page* 72]

CANDID COMMENTS: What Has Happened to Our Nurses

■ ORGANIZED NURSING must take a broader, bolder, and more down-to-earth stand on the major situations related to adequate patient care if the profession is successfully to weather its present crisis. This opinion, which I have long held, has now become a fixed conviction. A profession, charged with the great responsibility of providing nursing care for the American people, needs to do more than evaluate and strive to overcome its shortcomings in quality and quantity. It must, as well, evaluate and help change *all* the forces that are responsible for these shortcomings.

Janet M. Geister, R.N.

We agree it is "increased demand" that creates the gap between supply and demand of professional nursing—but we do not question whether all this demand is due to actual *need*. For the past 20 years nursing has unquestioningly accepted constantly increasing work overloads until hospital nursing has all but broken down. We have neither had nor asked for a voice in admitting policies. We have neither explored nor proposed the idea of limiting intake in order to provide skilled, safe care for those who need it most. We have not officially proposed the development of patient-caring resources other than hospitals for certain types of non-acute patients. We have not officially promoted the wider use of visiting nurses in home care, especially of children. An eminent pediatrician told the Michigan State Medical Society that "probably over 50 per cent of children hospitalized today could have been studied or treated at home," and other pediatricians are writing of the 'emotional trauma" of hospitalized children.*

We accept criticisms from doctors of our shortcomings, but we do not point out with equal justice the kinds of things doctors do that add immeasurably to the nursing load. We justly and vigorously push for better pay and better personnel practices for nurses—but we take no official cognizance of the wretched service a painfully evident minority of nurses are giving. The patients know it; their families and doctors and neighbors do too, but we don't mention it out loud. Yet the heartfelt response to Alice Clarke's editorial on poor nursing, and the letters about Evelyn Pastore's article on tipping, show how deeply good nurses resent bad nursing and unethical practices. We encourage the use of special nurses; we recognize the place of private duty in our

*See **R.N.** Nov. 1953, p. 50.

organizations—but we have never worked out a philosophy of the place of private duty in our health care program. Until private practice *knows* its place it cannot develop sound standards of practice, education, graded fee rates, integration with hospital policies, et cetera.

We have officially approved the use of qualified, trained practical nurses and aides, but we've taken no stern official stand against the *needless* and *heedless* exploitation of this approval in some institutions. We recognize the driving need for public opinion favorable to our problems and purposes, but our main efforts in public education go into publicizing our organizations and their works. Nowhere are we consistently telling the public the values of skilled nursing in human conservation, nor the beautiful, positive story of what good nurses are doing. There is an enormous volume of good nursing in contrast to the poor nursing that gets public attention. In the absence of our testimony, others are getting the unfavorable stories before the neighbors, or in the press.

This list of problems and projects that need vigorous, broad-gauge attack and action by our professional bodies is not complete. It serves, however, to give point to my conviction that our present approach is too limited, too highly concentrated within nursing, too vulnerable to outside critics whose own practices may be adding fuel to our fire. Too much of the burden of the nursing situation has been placed on the nursing profession. And just as we have patiently accepted the new work loads, so have we accepted the major blame for everything that is lacking in good patient care. There isn't a circumstance of any kind that can excuse a nurse for rudeness to patients, willful neglect, and sinful carelessness. But there are many nurses who are not guilty of these things, but only of not giving their best. We need to concentrate attention as much on the conditions that frustrate them in giving their best as we do on their sins of omission.

The main responsibility for planning and action in nursing affairs must remain within the profession, but we have to recognize more dynamically that the underlying causes of our major problems have roots outside our borders. We are more and more bringing into our councils the representatives of allied groups, such as medicine, education, and hospitals, as well as of the consuming public. Well and good! By the same token *we* need to move outward into *their* councils. More of us, moved by the examples of our leaders, should be able to take our part objectively and confidently in such councils. A hospital journal reports the statement of a hospital administrator at a meeting at which nurses were present that "the nursing profession has failed us." That remark called for a frank, open statement of where the responsibility for "failure" really began, and yet only veterans like myself know the old story of twelve-hour days, split shifts of work, $50 salaries. About twelve or fifteen years ago I summarized in published

articles some of the working conditions that were causing more and more experienced, loyal nurses to move away from hospital duty. I warned that the exodus would accelerate if conditions didn't improve. No warning in history ever got less attention.

There is little point, however, in looking backward to place blame. There is a great deal of point, however, in facing facts squarely today, in placing the responsibility where it belongs, and in taking our proper place in working out *with* our allies the tremendously complex problem of patient care and sickness prevention. The old attitude of considering nurses as "doctors' handmaidens" has disappeared—that of expecting nurses to live like hermits is disappearing. Many of our allies are in a more listening, receptive mood than in the past—more are ready to accept us on a partnership basis. But wrong old ideas are never easily given up, and new wrong ones crop up all the time.

The sacred obligation of the nursing profession to safeguard patients in every aspect of their nursing care has become infinitely more difficult and massive. We dare not accept passively some of the conditions now forced upon us by overloaded hospitals and the use of scores of thousands of untrained, inadequately supervised helpers in the nursing care of patients. We owe more dynamic, bold action to the patients, and we owe it to the grand army of

Probie

"Apparently that's not the high Fowler position."

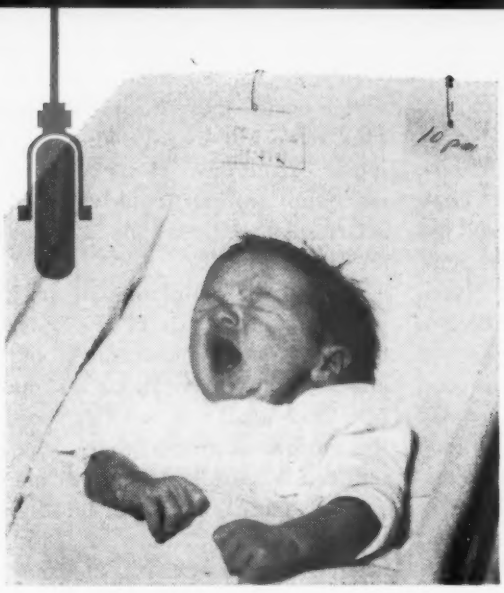
good nurses who are humiliated and in despair over many things now beyond their control. "The profession daily loses to some degree, the prestige it has earned," says Dorothy Casey of Cleveland. In this reference to "helpers" I am *not* referring to the trained, conscientious women of character who are giving such substantial aid but rather to the untrained, irresponsible Sairey Gamps who "know not what they do."

In nursing, one of the most tradition-bound of the professions, we tend to be guided much by the precepts, plans, and policies established by our official bodies. For example, it was *after* the Committee on the Grading of Nursing Schools recommended better health programs for students that such programs were generally adopted in our nursing schools, and our student tuberculosis rate began to drop. Only a few years earlier in analyzing the disabilities of our Relief Fund beneficiaries I had been shocked over the high incidence of this disease among recent graduates.

If, for example, our organizations took the stand that nursing should have a voice in hospital planning, nurses locally would be helped, both by the example offered and by the spread of an idea. Recently when I was being shown about a new 200-bed hospital addition I asked the nursing director, "Where will you get nurses?" She replied wearily, "Heaven only knows. We're already spread so thin that I feel like making rounds with my eyes closed." To my question, "Were you consulted about the nursing supply and the floor plans when the plans for building were made?" she answered, "Of course not. The only study of resources was of materials and the money to pay for them. I never even met the architect." We won't need to guess where the blame will fall when all those new patients get skimpy care, or none at all.

We're hearing often these days in our civic and professional associations, "*You* are the government. *You* are the association." That is correct —up to a certain point. An association of 1,000 members cannot have 1,000 spokesmen, each on his own tangent, if it wants to get anywhere. We elect presidents and boards of trustees who in turn appoint committees, and the task of all of them is to pool and clear our ideas and demands and set up a program of objectives and action. "You" are the association in that an association is a body of people with a voice and a vote, and you are one of them. But your power to act for the profession in your community or hospital or agency is almost nil unless your objectives represent the seasoned ideals of many nurses.

Recently the newspaper in a town of 50,000 carried a letter about nursing. A young married nurse who helps out part time in general duty grasped the opportunity to present to the public some greatly needed information on the nursing situation. Her thoughtful letter was well worth the time and effort she put into it. At the same time in a nearby large city, one [*Continued on page* 76]



Greetings!

by Henry C. Suter

New babies announce their own arrival at the Municipal Hospital, Tallahassee, Florida, since a microphone in the delivery room was wired to a loudspeaker in the "Stork Club," the room where expectant fathers wait. When the baby finally makes his or her debut, the doctor presses a foot pedal to open the circuit, and dramatically the baby's first cry goes out over the wires. In the background, the doctor announces the baby's identity, sex, condition at birth, and any other pertinent information. Incidentally, the father-to-be is no longer found pacing frantically up and down the hall for he now stays close to the loudspeaker, anxiously awaiting the news.

Robert W. Delaney, III, son of a local news reporter, was the first to test the hook-up. Radio station WTAL tuned in and relayed the first cry of the radio news reporter's baby to all those listening in.

Reporter Delaney also made a tape recording of the event, which he played on his regular program that evening. The recording, which featured his son's voice, also included the commentary by the doctor on the infant's weight and the condition of mother and son, plus a suggestion by Mrs. Delaney that her husband "go home and get some sleep."

Peripheral Vascular Disorders

■ ANYONE WHO has ever had his hand or foot "go to sleep" can understand the importance of the uninterrupted peripheral blood flow. That uncomfortable numbness followed by a tingling and pins and needles sensation serves warning that the blood should not be impeded in its passage through the extremities.

When the peripheral flow is obstructed for a longer time, the symptoms and consequences are more serious. This can readily be understood when it is realized that any disturbance in the peripheral circulation may interfere with its functions of carrying oxygen and nourishment to the tissues, permitting metabolic exchange to and from the capillary wall, and carrying away various waste products.

There are many factors underlying the impairment of peripheral circulation. That is why it is often convenient to divide the disorders affecting the blood supply to the extremities into two general classes: those which arise from organic sources, and those which are functional in origin.

Foremost among the organic diseases responsible for decreasing the blood flow to a limb is peripheral arteriosclerosis. In this condition, the arterial walls become thick and hard and lose their elasticity. More men than women develop this disease which occurs more frequently in persons over 50, usually affecting the lower extremities. However, diabetics, who are particularly prone to arteriosclerosis, may be afflicted at an earlier age.

The chief complaints of patients with arteriosclerosis of the extremities are apt to be coldness of the affected limb, sensations of numbness and pins and needles, pain in the muscles during exercise which is relieved by rest (intermittent claudication), pain that cannot be relieved by rest (rest pains), and muscle fatigue after exercise. On examination, it is not unusual to find atrophy of the skin and nails as well as muscles, absence of arterial pulsation when the vessel is occluded, and a delayed venous filling time. Arterial insufficiency is further indicated by rubor (discoloration or redness of the skin) when the affected extremity is in a dependent position, and pallor when the limb is raised above the level of the heart. The more serious sequelae of arteriosclerosis of the extremities, of course, are ulcers and gangrene.

Unfortunately, there is no cure for arteriosclerosis so treatment must be confined to promotion of circulation, with subsequent alleviation of symptoms. Both physical and emotional strains should be reduced as much as possible, although it should be

borne in mind that a reasonable amount of exercise may be beneficial because of its ability to increase the muscle's blood supply. It is generally recommended, too, that the patient follow a diet low in fat and cholesterol since high levels of cholesterol are frequently found in the blood of arteriosclerotic patients. In addition, the obese patient may be put on a low calorie diet, for overweight is likely to be associated with vascular accidents.

Among the drugs that may be of value in this disease are sedatives, antispasmodics, and the vasodilators. And when acute thromboses occur, anticoagulant therapy may have to be instituted. Whisky and aspirin

by Frances Lewis

are reported to be about as effective as more complicated agents in relieving the often agonizing rest pain. Definitely on the contra-indicated list are tobacco, ergot, and epinephrine because of their effect of constricting the small arteries and arterioles.

Another vascular disease of unknown etiology that is classified as organic in origin is thrombo-angiitis obliterans, more commonly known as Buerger's disease. Often found among young men under 45 years of age, this disorder, which affects the peripheral arteries, veins, and nerves, may pursue a chronic course or progress rapidly with develop-

Information for Patients of the Peripheral Vascular Clinic

1. **Keep warm.**
2. **Do not use tobacco in any form.**
3. **Take great care that the foot is not injured. Avoid crowded places.**
4. **Wear wide-toed shoes which cause no pressure and have adequate support for the arches.**
5. **Do not wear circular garters.**
6. **Do not sit with the knees crossed.**
7. **If the weight of the bedclothes is uncomfortable, use a pillow to hold the bedclothes above the feet.**
8. **Soak the feet in a basin of warm soapy water for five minutes every day. Dry thoroughly, especially between toes, by mopping, not rubbing.**
9. **Do not apply any medicine to the feet without directions.**
10. **If the feet are dry and scaly, rub with lanolin, olive oil, castor oil, or cold cream.**
11. **If the feet are moist, use talcum powder.**
12. **Before filing nails, soak feet in warm (not hot) water for five minutes to soften nails. File straight across. Do not file down into the corners. Do not file close to the flesh. Do not use a knife or razor blade.**
13. **Proper first aid treatment is important. Consult your physician immediately for any redness, blistering, pain, or swelling.**
14. **Do not attempt to treat corns or calluses. Ask your physician what should be done.**
15. **Drink an abundance of water, at least the equivalent of 20 glasses of water in each twenty-four hour period.**

From Amy Frances Brown: *Medical Nursing* Published by W. B. Saunders Company

ment of gangrene. Warning signals of the disease that may be ignored at first by the unsuspecting victim are coldness, loss of sensation, and burning and tingling in the extremities. The more strenuous the exercise, the more troublesome the symptoms, and as in peripheral arteriosclerosis, there is intermittent claudication associated with weakness and constriction of the extremities during exertion. The appearance of this latter symptom or phlebitis is what generally impels the patient to seek medical advice.

Also, in Buerger's disease there is a change in the normal color of the skin over the affected area, and one may notice swelling, ridged nails, corns and calluses, and red lines following the course of inflamed veins. Rubor of the limb when it is dependent and pallor when it is elevated are other cardinal signs. Rest pain is a late—and serious—symptom, for it appears prior to or during the gangrenous stage of the disease.

As in arteriosclerosis of the extremities, the treatment of Buerger's disease is merely supportive. But this doesn't mean that therapy is limited, for every effective means of increasing the blood supply is employed, ranging from the simple treatment of bed rest to the surgical procedure of sympathectomy.

Complete bed rest is desirable for the patient with ulceration, gangrene, or rest pain. And it is generally best if all patients suffering from Buerger's disease sleep with the feet lower than the heart, since this position will help the blood to fill and drain

Science Shorts

Ear wax may be a powerful protector of the ears from infections, Doctors Ben H. Senturia and Christopher Carruthers of George Washington University School of Medicine report. Scientists are searching for a substitute for ear wax which will protect servicemen in the tropics where less ear wax is produced and risk of infection is greater, especially if the men swim often.

■

Over ninety-seven million man-days are lost in the U.S. each year because of rheumatism, it was reported at the International Congress of Rheumatic Diseases held in Geneva, Switzerland.

■

Amyotrophic lateral sclerosis, the disease from which Lou Gehrig died, is the subject of a major study undertaken recently by the USPHS, the Navy Bureau of Medicine and Surgery, and the Department of the Interior. Guam was chosen as the site of the study because of the prevalence of the disease on that island. At present, there is no treatment for this disorder.

■

***Tolserol* (3-*ortho*-*toloxy*-1-2 *propanediol*) *appears beneficial in controlling or alleviating various drug withdrawal symptoms, Doctors John J. McLaughlin and Louis S. Schlan report in the* Illinois State Medical Journal.**

■

3-D electrocardiograph readings are now possible. A new apparatus, the stereovector-cardiograph, designed in the laboratory of the University of Michigan makes it possible for clinicians to make three-dimensional vectorcardiograms almost as easily as they now make recordings on a single plane.

Claims that "anti-enzyme" tooth pastes will prevent dental decay are unfounded, the *Journal of the American Dental Association* has declared. The Association's Council on Dental Therapeutics has stated that no dentifrice now being offered to the public has been shown to have a usefulness beyond that of aiding the toothbrush in cleansing the surfaces of the teeth.

■

Hansen's disease is a major health problem in Korea. About* 17,500 *patients are cared for in Korea's seventeen leprosariums and an equal number are outside these institutions.

■

The malaria control program undertaken by the Indian Ministry of Health, in cooperation with certain UN and U.S. agencies is waging a successful battle against this disease. Over ninety million of the more than 200 million persons living in endemic malaria areas in India are no longer troubled by the recurring spring attacks of malaria which formerly incapacitated them.

■

During the thirty-seven months of fighting in Korea, the fatality rate among American wounded was* 2.3 *per cent as compared with* 4.5 *per cent in World War II and* 8.1 *per cent in World War I (minus gas casualties).

■

The use of fish lens protein in cataract therapy is dangerous, the National Research Council has warned. A report in the *JAMA* states that promiscuous use of fish lens protein may cause an antigen-antibody reaction with the patient's own lens and inflammation and secondary glaucoma may occur.

the vessels of the affected extremity. Buerger's exercises, performed either actively or passively, are another method of promoting circulation in those cases where there are no open lesions or infection. These exercises, which produce alternating rubor and pallor, consist of lifting the extremity for a designated number of minutes then lowering it for another brief period. The same, or perhaps superior, results can be achieved through the use of an oscillating bed. Arteries may also be filled and drained by means of a "boot" which applies suction and pressure to the involved limb.

One way of relieving arterial spasm in Buerger's disease is through the intravenous injection of foreign protein, usually typhoid vaccine. Administered in the proper dosage, the vaccine should produce a slight temperature rise without a chill. Other methods of achieving the same result include the intravenous injection of tetraethyl ammonium chloride, the application of methacholine chloride by galvanic current, and the blocking of the sympathetic nervous system by procaine injection or by surgery (sympathectomy). Thrombosis, if it is present, will probably call for the administration of anticoagulant drugs. Vasoconstricting agents such as tobacco are strictly forbidden in Buerger's disease.

One of the peripheral vascular disorders that received a great deal of attention in World War II and the Korean conflict was frostbite or immersion foot. Brought about by prolonged expo- [*Continued on page* 63]

Drug Digest

BETA-PYRIDYL CARBINOL (Vasodilator)

PRODUCT NAMES: Roniacol Tartrate

PHARMACOLOGY: Roniacol, the alcohol corresponding to nicotinic acid, exhibits the vasodilator properties of nicotinic acid but its vasodilating action is more prolonged. As a result of its relaxing effect on peripheral blood vessels—specifically, the small arteries and arterioles—the drug has been used experimentally, and often successfully, in such conditions as endarteritis, Raynaud's disease, vascular spasm, intermittent claudication, Buerger's disease, varicose ulcers, chilblains, migraine with vascular spasm, Meniere's syndrome, and in certain cases of angina pectoris.

DOSAGE: Roniacol is available in the form of an elixir, containing 50 mg. of the drug per 4 cc., and in 50 mg. tablets. In peripheral vascular disease, dosage of the liquid may be one or two teaspoonfuls three times daily, or if tablets are preferred, one or two 50 mg. tablets three times a day. This dosage may be increased as indicated by the physician. Roniacol with aminophylline is also available in a single tablet containing 50 mg. of Roniacol and 100 mg. of aminophylline. Aminophylline with its vasodilator, cardiotonic, and diuretic action complements the direct vasodilator action of Roniacol.

UNTOWARD ACTIONS: Roniacol is reported to have a low toxicity. Side effects are usually minimal and rarely require discontinuance of the drug. They may include flushing of face and neck, a general feeling of warmth, and occasional dizziness and palpitation.

PAPAVERINE HYDROCHLORIDE U.S.P. (Antispasmodic and Vasodilator)

PRODUCT NAMES: Distributed under official name.

PHARMACOLOGY: Papaverine hydrochloride is the salt of an alkaloid obtained from opium, or prepared synthetically. Classified as a non-narcotic, nontoxic drug which does not lead to habituation or tolerance, it is not related to morphine chemically or pharmacologically. Nevertheless, it is subject to the Federal Narcotic Act. Because of its properties as a smooth muscle relaxant, it has a wide therapeutic application in spastic conditions of blood vessels, bronchi, gastro-intestinal tract, and in biliary and renal colic. It has also been used in the treatment of peripheral or pulmonary arterial embolism and coronary occlusion since it increases collateral circulation in reflexly constricted vascular beds. Some of the peripheral vascular disorders in which papaverine is employed are Buerger's disease, frostbite, and the acute arterial occlusion caused by peripheral lesions in arteriosclerosis.

DOSAGE: Oral dosage varies from 100 mg. to 300 mg. three, four, or five times daily. The intravenous dosage ranges from 32 mg. to 130 mg. The drug is available in ampuls, tablets, and powder. Large doses may be given intra-arterially to an affected extremity in the emergency treatment of acute arterial occlusion.

UNTOWARD ACTIONS: Papaverine has a relatively low toxicity, but side effects such as nausea, dizziness, and constipation may occur occasionally. Because of its depressant action on heart and blood vessels, intravenous injections should be administered slowly and with caution.

PHENOXYBENZAMINE HYDROCHLORIDE (Vasodilator)

PRODUCT NAMES: Dibenzyline

PHARMACOLOGY: Dibenzyline, a long-acting adrenergic blocking agent, produces its vasodilating action by blocking pressor effects from such adrenergic substances as epinephrine and nor-epinephrine as well as by blocking motor impulses from sympathetic nerve endings in the muscular walls of the arterioles. Because of its ability to block sympathetic impulses, Dibenzyline is employed most effectively in conditions characterized by vasoconstriction, especially where there is undue sympathetic stimulation. These disorders include Raynaud's disease, acrocyanosis, hyperhidrosis, chronic ulcerations of extremities, and causalgia. It may also be used in frostbite, trench foot, intermittent claudication, arteriosclerosis obliterans, diabetic gangrene, and Buerger's disease. In the hypertension of pheochromocytoma, Dibenzyline lowers blood pressure to within normal limits.

DOSAGE: The dosage of Dibenzyline, which is administered orally, will depend on the individual patient. In any case, the initial dosage should be low and gradually increased until the therapeutic effect is achieved or until side effects require discontinuance. In peripheral vascular disease, the dosage may range from 20 to 60 mg. daily.

UNTOWARD ACTIONS: The drug is contra-indicated in those conditions where a decrease in blood pressure is not desirable. It should be given with caution to patients with cerebral arteriosclerosis or renal damage and those with respiratory infections. Side effects of nasal congestion, tachycardia, miosis, and postural hypotension will tend to decrease as therapy is continued.

TOLAZOLINE HYDROCHLORIDE (Vasodilator)

PRODUCT NAMES: Priscoline

PHARMACOLOGY: Classified chemically as an imidazoline derivative, Priscoline has been studied intensively in recent years for its pharmacological action and therapeutic effect in peripheral vascular diseases and associated disorders. It is believed that the drug produces peripheral vasodilatation by blocking tonic sympathetic vasoconstrictor impulses and acts directly by vasodilatation on the smaller blood vessels. The drug has been reported to be of value in Raynaud's disease, thromboangiitis obliterans, thrombophlebitis, intermittent claudication, and diabetic vascular disease with or without gangrene. It is also employed as a diagnostic and prognostic agent in peripheral vascular disease in order to ascertain the degree of angiospasm and to gain some idea of the value of performing a sympathectomy.

DOSAGE: Oral dosage of the tablets or elixir may consist of 25 to 50 mg. every three or four hours. The same dosage may also be administered subcutaneously, intramuscularly, or intravenously. The physician generally starts with low doses and increases them slowly until optimal therapeutic dosage has been achieved. Flushing is generally an indication of optimal dosage.

UNTOWARD ACTIONS: The drug is contra-indicated in collapse and shock, and should be given with caution to patients with peptic ulcers, gastritis, and coronary disease. Because of the possibility of postural hypotension, patients receiving injections of high dosage should be kept in a recumbent position for an hour after injection, or until the blood pressure has become stabilized.

News in Review

► *THE ISRAELI PARLIAMENT* has adopted a compulsory national insurance program which will cover the aged, survivors, maternity cases, and victims of industrial accidents. All industrial workers will be covered by accident insurance which will provide for complete or partial payment of hospital fees for from two to twenty-six weeks as well as compensation in case of disability. A twelve-week maternity leave at three-quarters pay will be instituted for working women, as well as maternity benefits of $30 for all mothers to cover the costs of layette and hospitalization. Men of 65 and women of 60 are to be eligible for old-age pensions after a period of five years. However, men of 67 and women of 62 who were residents at the time the law was adopted may receive pensions after only three years of paying premiums. They will receive the equivalent of $8.80 a month plus cost of living allowances. This modest sum was agreed upon because it was believed that most wage-earners would receive additional pensions through existing collective bargaining agreements. Payments for widows and orphans are comparable to old-age pensions although widows under 50 will receive smaller payments.

✔ ✔ ✔

► *THE DEFENSE DEPARTMENT* has announced its intention to sponsor a program of government scholarships for nurses, medical students, dentists, and, within limits, veterinarians. It is planned that for each year the scholarship is in effect, the recipient will serve one year in the military services . . . The Defense Department will also probably include a Survivor Benefits plan in its 1954 legislative program unless there is an objection from the Bureau of the Budget. The proposed legislation would place all members of the armed forces drawing basic pay under Social Security coverage, and would also seek more equitable compensation for survivors of military personnel who die or are killed while on active service.

✔ ✔ ✔

► *WAYS TO DETERMINE COSTS* of basic nursing education programs in public and privately supported colleges and universities with both large and small enrollments are being explored by the National League for Nursing. Five schools of nursing — Seattle's University of Washington; Loretto Heights Department of Nursing,

Denver; University of California, Berkeley; and Emory University, Atlanta—are taking part in the project; a pilot study has been completed at Skidmore College in New York. Later, additional schools will be asked to participate.

► *PERSONNEL SHORTAGES CAN BE MET* by most of the nation's hospitals with no expansion of their present staffs, according to the Health Resources Advisory Committee of the Office of Defense Mobilization. The committee urges hospital administrators, doctors, and nurse-executives to discard tradition and look at each task anew to determine whether it is necessary for the patient's welfare and whether it is being performed in the most economical manner from a personnel standpoint. In a brochure entitled, *Meeting Your Hospital Personnel Shortage*, available upon request from committee headquarters in Washington, the following recommendations are made: (1) The use of the team approach; (2) use of modern management technique to increase productivity of workers; (3) recognition of the primary importance of job satisfaction and of the need for salary scales commensurate with local markets; (4) attention to the development of leadership skills; (5) leadership by doctors in the use of paramedical personnel; (6) effective leadership by chiefs of medical departments in teaching doctors to cooperate in administrative routines, etc.; (7) a wider concept of nursing functions for the purpose of delegating the supervision of institutional services to other departments; (8) a continuing job analysis to ensure that personnel are being used to the greatest advantage; (9) staff cooperation in reviewing routine procedures, and in the standardization of equipment, etc.; (10) better ways of recruitment, training, and in-service training of all levels of personnel; and (11) the consideration of newer architectural developments in hospital planning.

► *CAPITOL COPY*: Federal grants in excess of $29 million have been made to 3,123 seriously disabled veter- [*Continued on page 68*]

About People

► Newest member of the Health Resources Advisory Committee is NLN president *RUTH SLEEPER*... A Nursing Education Section has been created in the Education and Training Division of the Office of the Army Surgeon General. *MAJOR IDA GRAHAM PRICE* has been named Chief of this new Section... The Business and Professional Woman's Club of Sioux Falls, S.D., has honored *IRENE FISHER*, director of nursing service, Crippled Children's Hospital and School, as the city's 1953 "Woman of Achievement"... *EDITH ROBERTS*, formerly of Teachers College, Columbia University, is now director of nursing at Methodist Hospital of Brooklyn, Brooklyn, N.Y. . . Two Cleveland sisters, *ANNA* and *MARY PEPPER*, have completed a total of 103 years of nursing service.

THE PAY-OFF

■ WHAT MAY PROVE to be the decisive campaign in the war against polio, is the forthcoming vaccination program of the National Foundation for Infantile Paralysis. Scheduled to begin during the week of February 8, the wide scale field test will involve from 500,000 to 1,000,000 children in the second grade of school.

Children in this grade, whose ages usually range from 6½ to 8 years, will receive three injections of the vaccine, each dose measuring 1 cc. The first two doses will be spaced at one-week intervals, the third dose, which serves as the "booster shot," will be given not less than four weeks later. All injections will be in the arm. Participation in the test is voluntary with the consent of parents or legal guardians.

In order to evaluate the protective effects of the vaccine—which stimulates immunity against each of the three known types of polio virus—the children in the first and third grades will not be injected. The incidence of paralytic polio in these grades can then be compared with the incidence in the vaccinated grades. Other controls will include the brothers and sisters of the vaccinated children, and those in the second grades who do not receive the injections.

Although the more than 200 coun-

FOR POLIO?

ties in the U.S. that will be included in the study have not yet been selected, the program will get underway in twenty to twenty-five Southern counties where the disease begins earliest. All vaccinations must be completed by June 1, 1954, before the polio season begins.

To insure the validity of the study, criteria for the selection of the counties include: a high polio incidence for the past five years; a high epidemic rate in the past five years during June through September; a high attack rate in a specific age group; adequate health and education facilities; and socio-economic factors, geographic location, etc. to provide a significant cross-section study.

The safety of the polio vaccine, which is a killed virus of the three known polio-producing types, is emphasized by NFIP spokesmen and Dr. Jonas E. Salk, Research Professor of Bacteriology at the University of Pittsburgh, who developed the vaccine under a grant from NFIP. As a triple safety procedure, the vaccine will have to pass three independent safety tests before its administration, one performed by the commercial manufacturer, one by Dr. Salk, and the third by the Biological Standards Division of the National Institutes of Health, the branch of the U.S. Public Health Service that licenses and controls the manufacturing of all biological preparations.

Dr. Salk has already reported on preliminary studies in which nearly 700 children and adults, including his own wife and three children, have received the injections without ill effects. His reports based on this group reveal that vaccination does stimulate the body's production of polio antibodies within a few weeks. There is evidence, too, that these antibodies indicate the person's ability to resist paralysis.

Before the NFIP program begins, Dr. Salk plans to conduct further studies in Allegheny County, Pa., involving the vaccination of 5,000 to 10,000 children. In the nationwide tests, local physicians will administer the vaccine under the supervision of county health officers.

The Foundation, which expects to spend $7,500,000 of March of Dimes funds on its mass vaccination program, will have to wait until 1955 for the final results. Until such time, researchers will not know definitely whether the vaccination produces antibodies capable of preventing paralytic polio in children exposed to the disease under natural conditions. And then and only then will the public know whether the crippling foe of polio has finally been vanquished.

Vascular Disorders

[*Continued from page* 55]

sure of the body to cold, the severity of the frostbite depends on the environment to which the patient has been exposed, that is, the temperature, moisture, etc., and also upon the condition of the patient. There is a greater susceptibility to frostbite among the very young and the old as well as among those with diabetes and heart disease.

Frostbite is characterized at first by erythema or blanching, then by superficial blisters and injury to the tissues, and finally by gangrene. If treatment is begun early, about six to sixteen hours after exposure, gangrene may be prevented. There is some controversy as to the application of heat in frostbite. The traditional view has been that the frostbitten part should be thawed gradually in cool water or in a cool room. Recently, however, the American Red Cross has revised its first aid treatment of frostbite in accordance with recommendations of the Committee on Surgery, Division of Medical Sciences of the National Research Council.

The ARC now advises that the frostbite victim be brought into a warm room or wrapped in warm blankets. Until he can be brought indoors the frozen part should be covered with woolen cloth and the person given a warm drink. Rewarming is accomplished by placing the frozen part in a container of lukewarm water (70° to 78° Fahrenheit). After re-warming, the part should be exercised. There should be no rubbing of the affected area. More specific treatment may consist of elevation of the extremity, use of a heat cradle, administration of the anticoagulant, heparin, and paravertebral sympathetic blocks, and vasodilating drugs.

Under the category of functional vascular disorders may be found those conditions which are initiated either by "disturbances in the sympathetic innervation of the blood vessels," or by organic vascular disease.[1]

Actually, in Raynaud's syndrome, which falls within the group of vascular diseases referred to above, there is some question as to specific etiology; probable stimulating factors range from cold sensitivity to neurosis. According to one authority, the vasospasm, which is the chief characteristic of the disease, "may be initiated by cold or neurogenic factors or other causes."[2] Women in the twenties, thirties, and forties are the chief victims of the disease.

The diagnosis of Raynaud's syndrome depends on bilateral involvement of affected areas—although the onset may be unilateral—blanching of the fingers or toes alternating with rubor, gangrene, or trophic changes in the superficial tissues; and an absence of occlusive lesions of the main arteries. If cold sensitivity seems to be the stimulating factor, the patient is advised to guard against cold by dressing warmly and using such devices as chemical hand warmers and

[1] *The Merck Manual of Diagnosis and Therapy*, p. 210.
[2] *Arizona Medicine*, November, 1953, p. 391

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car heaters. However, excess heat should be avoided. In certain cases, sympathectomy may have to be resorted to in order to alleviate persistent symptoms.

One of the most painful syndromes associated with vasospasm is causalgia, a condition due to injury or irritation of a peripheral nerve. The burning pain of causalgia may make the patient keep the affected limb immobilized thus contributing to muscle atrophy. Sympathectomy has been used successfully in severe cases, and in the less painful forms, vasodilators and procaine nerve blocks have controlled symptoms.

In a brief resume of peripheral vascular disorders such as this, it is difficult to treat each disease in detail. Furthermore, in the case of these disorders, certain generalizations can be made concerning treatment and nursing care of the whole group. The instructions on page 53, for example, can be followed to good effect by almost every patient attending a peripheral vascular clinic. It might not be a bad idea, though, to add one more point to this list, and that is the danger of applying heat to the limbs of patients with peripheral vascular disease. Nurses as well as patients should never forget that severe burns can result when hot water bottles or other warming devices are applied carelessly to areas with a poor blood supply.

In addition to these general rules, it can be stated that, with few exceptions, tobacco is frowned upon by doctors treating peripheral vascular disease, for there is adequate evidence to prove that vasoconstriction will be produced by smoking. Some patients, however, are not too unhappy to learn that they are permitted and even encouraged to take alcohol because of its vasodilating properties.

Vasodilating drugs play an especially important part in the treatment of peripheral vascular diseases, and, in some cases, may substitute for the surgical procedure of sympathectomy by performing what is, in effect, a reversible chemical sympathectomy. The vasodilator drugs discussed in *Drug Digest*, page 56, include papaverine, classified primarily as an antispasmodic; Roniacol; Dibenzyline; and Priscoline. Other vasodilating agents such as Etamon Chloride or tetraethyl ammonium chloride (**R.N.**, January, 1950, page 48) and Mecholyl Chloride or methacholine chloride (**R.N.**, November, 1953, page 43), as well as certain vasodilating agents described in June, 1953, are employed.

Though the etiology of the peripheral vascular diseases remains obscure, there seems to be no limitation to the amount of pharmacological research being done in this important field.

Offensive odors can be overpowered by burning several kitchen matches in succession, according to the chief chemist of the Diamond Match Company. Perfumes and incense simply make odors less noticeable. The sulphur dioxide released from kitchen matches, however, overpowers all other odors.

Trials and Trends

[*Continued from page* 35]

voted to adopt the ANA Economic Security Program but couldn't get a dues increase to pay for it, and ended up by receiving voluntary contributions.

Group Insurance

The less publicized aspects of an economic security program, relating to various types of insurance—retirement, accident and health, etc.—are creating more and more interest among nurses, and state associations are endeavoring to meet these very real insurance needs by providing or investigating group insurance plans. Malpractice insurance is apparently not discussed as much as other types of insurance, but malpractice itself and all the legal aspects of nursing continue to be a popular subject for speakers at conventions as well as for writers in state bulletins. The question of whether a nurse should give I.V. injections or whether this falls within the practice of medicine is becoming less and less a matter of mere academic interest.

In fact, many of the functions of nursing are undergoing more critical analysis with the current emphasis on nursing research. And more and more nurses are getting survey and statistics conscious, as shown by the increasing number of personnel policy surveys and other types of questionnaires that are being directed to SNA memberships.

"Hopes" of the Future

If some state associations seem to be stagnating because of lack of interest on the part of the membership, the state student associations everywhere seem to be speeding ahead. In one Southern state the belief was expressed by the students themselves that the student association was used to foment dissatisfaction with nursing school policies. In this particular instance, directors of schools understandably did not encourage membership. But on the whole, state student associations were being regarded by their organizational elders with parental pride. "Our future nurses of tomorrow" was a phrase that echoed from Massachusetts to Florida during the convention months of October and November.

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News

[*Continued from page* 59]

ans for the construction of "wheelchair" homes. The VA pays 50 per cent of the cost up to a maximum of $10,000. To be eligible, veterans must be entitled to compensation for the loss of or loss of use of both legs due to certain specified conditions . . . New highs have been attained in the number of Americans protected against sickness costs by enrollment in some sort of health insurance plan. In 1952, 91.6 million were covered by hospitalization insurance, 7 per cent more than the 1951 total. The number of persons holding surgical benefits rose to 73.1 million, a 12 per cent increase, and the number of persons holding medical care benefits climbed to 35.8 million, representing an increase of 29 per cent. At the end of 1952, 689,000 persons carried indemnity-type "catastrophic cost" insurance . . . The second Hoover Commission on governmental reorganization has announced its intention to work for the unification of all federal medical services—military as well as civilian . . . Dr. Chester Scott Keefer, professor of medicine at Boston University and physician-in-chief at Massachusetts Memorial Hospital, has been named special assistant to the Secretary of Health, Education, and Welfare for health and medical affairs.

► HONORED IN ENGLAND for her work in the Harrow-Wealdstone train disaster over a year ago—the cause of 110 deaths—is Capt. Abbie

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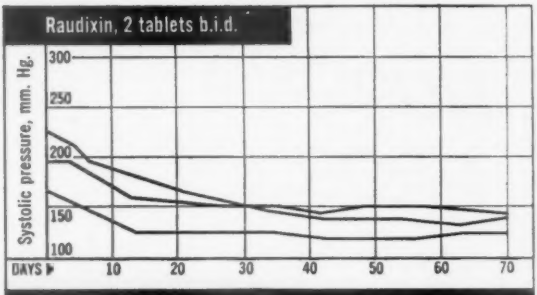
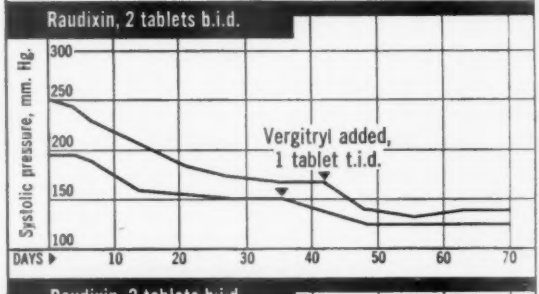


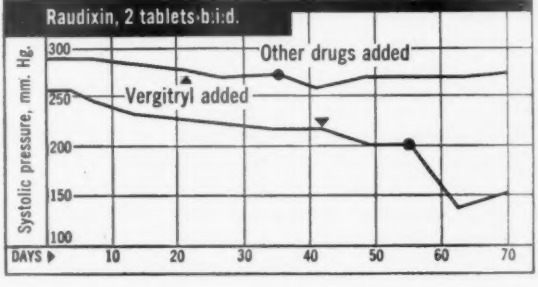
step 2

If blood pressure is not adequately controlled in four to eight weeks, Vergitryl (veratrum) may be added to Raudixin. This brings many of the remaining patients under control. Raudixin tends to delay tolerance to Veratrum, and makes smaller dosage possible.



step 3

For the few patients resistant to this combined regimen, a more potent drug may be added, for example, Bistrium (hexamethonium). The most potent drugs, which are potentially dangerous, are thus used only as a last resort in the most refractory cases.



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Sweetwine of the U.S. Air Force Nurse Corps, a Negro nurse from Cocoa, Fla. Captain Sweetwine was first on the scene of the wreck with plasma for the wounded. Known to many in England as the "Angel of Platform 6," Captain Sweetwine was named "Woman of the Year" by the Variety Club of Great Britain and was praised by Gen. Hoyt Vandenburg, then Air Force chief of staff.

► LATEST GRANTS from the American Nurses Association for nursing functions studies include: $11,625 to the Pennsylvania State Nurses Association for research by the Department of Sociology, University of Pennsylvania in the social-psychological characteristics of potential student and graduate nurses; $11,800 to the Institute of Social Research, University of Missouri for investigation of the work of the staff nurses in rural general hospitals in central Missouri; and $2,350 to the Arkansas State Nurses Association for a study by the University of Arkansas of nursing functions in a 100-bed general hospital. To date, the ANA has awarded $130,000 in fifteen grants.

► STORY-A-DAY, a new weekly magazine edited for children in the 3-to-7 age-group, is being distributed nationally by various chain stores in the food field—among them Grand Union, Acme, First National, Colonial, and National Tea. The publishers say that each issue will feature seven original stories, written

and illustrated for parent and child to peruse together. The 32-page weekly sells for 25 cents an issue.

▶ A GUIDE FOR HEAD NURSES is the first publication to be prepared by the Department of Hospital Nursing of the National League for Nursing. Entitled, *The Head Nurse at Work*, this sixty-page handbook is designed to serve as a combination workbook and ready reference. According to Marian Alford, director of the Department, the booklet was devised to familiarize the head nurse with principles of organization and administration; to help her recognize her responsibilities and improve her methods of carrying them out; to suggest ways of improving patient care; and to ensure the better utilization of available personnel. A special committee of five head nurses and four consultants, appointed by the National Committee for the Improvement of Nursing Services, outlined suggestions for the contents of the guide. Copies may be ordered from the National League for Nursing, 2 Park Avenue, New York 16, New York. Price: $1.00 per copy.

▶ BUDGET CUTS in the Federal Civil Defense Administration have led to the closing of two regional offices. In the revised set-up, there is one ANA representative serving on the health advisory committee of each of the seven regional offices. These nurse representatives, who are state executive secretaries nearest to the location of the FCDA regional offices, will not only represent ANA and keep it informed but will also represent nursing from each state included in the region. Regional Offices abolished are those at Seattle, Wash., and Cleveland, Ohio. Regional offices now open and their ANA representatives are as follows: Region I, Boston, Mass., Edith V. Peterson; Region II, Philadelphia, Pa., Hazel Knibb; Region III, Atlanta, Ga., Mrs. Mildred B. Pryse; Region IV, Chicago, Ill., June A. Ramsey; Region V, Dallas, Texas, Carrie M. Spurgeon; Region VI, Denver, Colo., Elizabeth M. Rauch; Region VII, San Francisco, Calif., Shirley C. Titus.

▶ NEWSLINGS: The first national meeting of the Associations of Operating Room Nurses will be held February 1-3 in the Hotel New Yorker, New York City. All operating room nurses are invited to attend . . . The school of nursing at the University of Michigan reports a record enrollment of 158 students in its first year program . . . A prefabricated aluminum hospital is now being erected in Sydney, Australia. Complete with wards, operating theater, x-ray, outpatient and casualty departments, this hospital, the largest of its kind in the world, will accommodate 100 patients . . . Thirty-three states now require some form of health education in secondary schools, according to a Federal government report. Copies of the report, "Health Instruction in Secondary Schools," may be secured at 10 cents each from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C.

Menopause

[*Continued from page* 46]

condition, as well as the patient's response to treatment. Where vasomotor symptoms are very severe, and flushes occur 15-20 times a day, and so frequently during the night as to disturb the patient's sleep, hormonal therapy is extremely beneficial.

Several of the signs and symptoms of the menopausal state are similar to those ascribed to a vitamin B deficiency. Therefore, it is not surprising to find that some menopausal patients are relieved of headaches, insomnia, numbness, and pain in the upper and lower extremities, mastalgia, and other tension symptoms with administration of vitamin B Complex.

The responsibility for a sane menopause rests first and foremost upon the women themselves. Medical science through the physician may alleviate menopausal symptoms and produce a gratifying sense of well-being, but it can never bring back youth to anyone—at least, not yet. A healthy outlook must be earned through self-discipline, intelligence, and effort.

Your Daily Life

More rest and relaxation is needed during the menopause. Many nurses during this period are forced to full-scale activity as nurses. Nursing is a physically and mentally tiring profession—a profession which places the needs and interests of others first. One of the first considerations for the nurse, then, is to force herself to slow down during this period. Besides the usual 6-8 hours of sleep, one full day's rest is helpful.

A vacation annually, or oftener if it can be managed, particularly during the menopause, fills a need for change and orientation. Many nurses at this age are mothers of grown children and have never really had a vacation away from their families. Other older nurses have gone back to full-time nursing in addition to carrying on their responsibilities at home, some of them working to supplement or increase the family income, some to use their skills and abilities where they are urgently needed. The optimum vacation for most people is somewhere in the

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A-200

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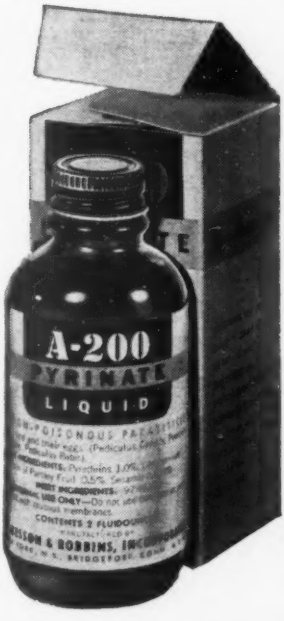
kills head, crab, body lice, and their eggs ...on contact!

8,000 CLINICAL TESTS in the District of Columbia jail prove A-200 Pyrinate highly effective in killing both parasites and their eggs . . . on contact!

A-200 Pyrinate Liquid is easy to use, no greasy salve to stain clothing, quickly applied, easily removed, non-poisonous, non-irritating, no tell-tale odor . . . one application is usually sufficient.

The active ingredients of A-200 are Pyrethrum extract activated with Sesamin, Dinitroanisole and Olearesin of Parsley fruit, in a detergent-water-soluble base. The pyrethrins are well-known insecticides and Anisole is a well-known ovicide, almost instantly lethal to lice and their eggs, but harmless to man. A-200 Pyrinate Liquid has won quick and general acceptance by the profession wherever it has been introduced.



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vicinity of four weeks annually to make up for the year of work.

An Avocation

Absolute idleness is not beneficial to a normal woman during the menopause. A hobby, an avocation, an interest in something other than the day-to-day routine is essential at this time of life. For the younger nurse, it might be well to start early with some avocation and grow up with it in a limited way so that when the time comes, there will be a definite basis to go on. The continuous use of one set of mental and bodily activities, year in and year out, is dull and wearisome. It is most fun to do something enjoyable, and thus completely forget our workaday selves for even a little while. (For those who have been retired, nursing offers a splendid opportunity in this direction.)

Advice to the Young

Women who are unable to adapt physically and mentally to the premenstrual hormone decline, and who suffer from exaggerated premenstrual depressions and other abnormal organic states are those who usually suffer from the vegetative discomforts of the menopause. Since the fuse of menopausal troubles is lighted in youth, the young nurse can begin early by establishing good physical and mental health habits, so that she may meet the basic needs of adult womanhood and later life. A body with a reasonably favorable inheritance factor, that has been kept reasonably healthy and well nourished, is likely to give good performance during the menopause.

FIT

for a nurse...

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Start off on the right **shoe** this year... Clinics! Make a resolution to wear your right **size** and **width!** Determine to stick with a shoe that's **softer... stronger... smarter!** Try on a pair of Clinics today!

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AAA		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
AA		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
A	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
B	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
D	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
E	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

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Candid Comments

[*Continued from page* 50]

of its most important newspapers devoted its major editorial space to an intelligent discussion of the nursing shortage that kept two large new hospitals from opening. Here was an almost made-to-order opportunity for organized nursing to speak its piece to the public. Instead there was complete silence, though organized nursing in that particular area has ample public relations resources. I've concluded that our members are often ahead of our leaders in their thought and action, a conclusion that was borne out in these instances.

There is no question but that the increased stature of nursing demands increased stature in nurses. None of us can demand protection and progress from the profession unless we give to that profession. But we have to be guided by the platform, principles, and objectives set up by the leaders we elect for that purpose. It is the quality of their courage, vision, forthrightness, and intelligence that determines in the final count, how ably our profession will meet the great challenges of today.

The Army Medical Service has decreed that all hospital personnel attending patients must wear identification badges of dark russet leather. The badges were ordered because of the belief that "the patient . . . realizes a more secure feeling when he can identify by name those who are entrusted with his care."

Candid Comments

[*Continued from page* 50]

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Types of Investment

[*Continued from page* 40]

the individual stockholder is not assured that the dividend for that year will be made up in a future earning period. However, there are some types of preferred stock called *cumulative*, which declare that if an interest period passes without a dividend the dividends will accumulate and will be paid at a later period, if and when earnings justify such a payment.

Convertible preferred stock gives the owner the right to convert preferred stock into common stock if and when he desires. Sometimes this conversion is favorable, sometimes it is not.

Municipal securities are those issued by governmental institutions such as cities, counties, states, drainage districts, etc.

Utility bonds are those issued by companies manufacturing and distributing gas and electricity or distributing water.

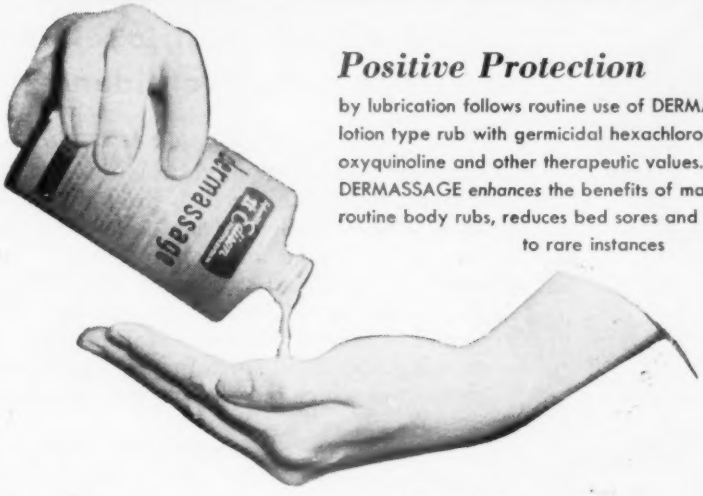
Rails are bonds issued by railroad companies.

Corporates are bonds issued by corporations other than the ones already mentioned.

(Readers may find it helpful to clip this article and the one in the preceding issue for future reference. In articles to come, more details will be provided, and suggestions will be made concerning the development of a safe and successful economic security program for the future which can be used as a guide for those who are interested in investing.)

Have You Adopted **THE SKIN CARE METHOD** *that*

WRITES OFF BED SORES AND BED CHAFE?



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by lubrication follows routine use of DERMASSAGE—lotion type rub with germicidal hexachlorophene, oxyquinoline and other therapeutic values. DERMASSAGE *enhances* the benefits of massage and of routine body rubs, reduces bed sores and bed chafe to rare instances

TEMPORARY EASEMENT

with repeated drying out of the skin result from rapidly evaporating rubs, which also make skin susceptible to cracking and soreness.

1000 CC. H_2O
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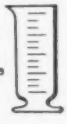
Due to the marked affinity of alcohol for moisture, the contents of the 1 cc. pipette above, added to the 1000 cc. of water, will be immediately dispersed through it. THUS alcohol tends to remove the natural moisture of the skin when applied to it.



MATERNAL MORTALITY? Steadily declining.

SEVERE SURGICAL SHOCK? Frequency greatly reduced.

BED SORES? Where DERMASSAGE therapeutic lotion rubs are routine, *practically a closed chapter in medical and nursing history.*

Even the vexation of minor sheet burns is reduced to the vanishing point in the overwhelming number of cases where DERMASSAGE care has been adopted.

The reason for success of this method is as inescapable as most other scientific truths, once established: skin chafing and bed sores can be *prevented* in nearly every case by regular application of a softening, emollient rub—especially one which also reduces risk of infection . . . DERMASSAGE not only avoids the skin drying effects of earlier rubs, but gives *positive protection* against chafing and soreness.

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ANESTHETIST: Wanted immediately for 100 bed hospital. Liberal personnel policies. Salary $400 per mo. Apply Director of Nurses, St. Mary's Hospital, Green Bay, Wis.

ANESTHETIST: Registered Nurse with 3 or more years experience. Salary $461.50. Laundry furnished, 40 hr. week, 2 week vacation, 12 days sick leave, 7 paid holidays annually. Anesthesiologist in department. 200 bed hospital. Apply Personnel Director, Pontiac General Hospital, Pontiac, Mich.

ANESTHETIST: Starting salary $350 mo. Methodist Hospital, 6th St. and 7th Ave., Brooklyn, N.Y. SO8-6000, Ext. 142.

ANESTHETISTS: A.A.N.A. member. 250 bed general hospital, salary open, automatic increases, laundry provided, 40 hr. week, no obstetrics, liberal vacation and personnel policies, Social Security. Sutter Hospital, Sacramento, Calif.

ANESTHETISTS: (a) To assist in development new 400 bed teach'g center in foreign city 350,000 sponsored by wealthy American Foundation, Far East, mild tropical climate. Lge. Amer. Colony. $6800. $1000 for transport. of goods plus all travel exp. (b) Reg'd vol. gen'l hosp. 27 beds. $6000 or fee basis, Popular tourist town 25,000. SW. (c) Gen'l hosp. 130 beds. $7200. Excel. summer, winter hayfever resort. Mich. (d) Gen'l hosp. small size. $7200. Lge. city univ. med. center not far from Chgo. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ANESTHETISTS: (a) Three. New 210 bed private gen'l hosp. Staff of 6 anes. res. town, MW. $500-$600. (b) Group, 7 Board men, resort town, Fla. $500. (c) Ass'n 10 man group coll. town, SW. (d) Two. Anes. group, coll. town, E. (e) New gen'l hosp. Honduras. (f) Ass'n, anes. group. Calif. (g) Small gen'l hosp. univ. city, MW. $500-$600. (h) New hosp. 300 beds, lge. city, Pac. Coast. $450-$500. RN1-2 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANESTHETISTS: 450 bed teaching hospital. Department directed by medical anesthesiologist. Southern city with cultural advantages. $400 per mo. with full maintenance. Periodic increases in salary. Liberal vacation and sick leave. Hospitalization and pension plan benefits. Apply C. A. Robb, Superintendent, Roper Hospital, Charleston, S.C.

ASSISTANT DIRECTOR OF NURSES: Large hospital Chicago suburban area. College affiliated. Degree in nursing education required. Salary dependent upon qualifications and experience. Write Box WHS-1 c/o R.N. Magazine, Rutherford, N.J.

CLINIC, INDUSTRIAL, OFFICE, SCHOOL: (a) Research assistant, med. school research dept. Training provided. MW. (b) Courier nurses, transcontinental. (c) Student health nurse, coeducational coll. W. (d) Direct. nursing staff, business office, well known group, E. (e) Two clinic nurses, one to assist surgeon, other pediatrician, Calif. (f) Student health nurse, co-ed. coll. MW. (g) Indus. nurse, leading company, Chicago. (h) Indus. nurse consultant. Leading insurance co. Some travel. (i) School nurse, boarding school, SW. RN1-3, Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

CLINICAL INSTRUCTORS: In the Medical and Surgical areas. 332 bed hospital located in an attractive residential section. Student body of 160. Degree in nursing education and some teaching experience preferred. Salary range for 40 hr. week $320-$430. Beginning salary commensurate with experience and preparation. Liberal personnel policies. Living accommodations available. Apply to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio

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fications) McPherson Memorial Hospital, Howell, Mich.

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FACULTY POSTS: (a) Ed. dir. fairly lge. gen'l hosp. 200 students, interesting city outside U.S.. mild climate. (b) Instructors in OR, ob., ped. Univ. hosp. Pac. Coast. (c) Ass't nursing arts & med-surg. instructors. Collegiate school, coll. town, MW. $4200-$5000. (d) Nursing arts & clinical. Vol. gen'l hosp. 200 beds. Res. town, N.J., near NYC. RN1-5. Burneice Larson. Medical Bureau, Palmolive Building, Chicago, Ill.

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GENERAL DUTY NURSES: For new 30 bed hospital located in college town of 6,000 population in Southwestern Wisconsin. Laundry furnished, 44 hr. week, beginning salary $285, increases 6 mos. and 1 yr. Apply Administrator, Platteville Municipal Hospital, Platteville, Wis.

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week. Prevailing salaries paid. Full maintenance available. Apply Director of Nurses, Redlands Community Hospital, Redlands, Calif.

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GENERAL STAFF NURSES: This is a nice place to work in preferred department of 200 bed general hospital with liberal personnel policies including 40 hr. wk., choice of two schedules, retirement plan, paid hospitalization insurance premium, cumulative 30 day sick leave, pro-rated and progressive vacation, 6 holidays annually, meals at cost, rooms for $20 monthly in residence beautifully located directly on Detroit River and 30 minutes from Detroit. Beginning salary, evenings $304.47-$313.13; nights, $299.47-$308.13; days, $289.47-$298.13. For details write Director of Nursing, Wyandotte General Hospital, Wyandotte, Mich.

GENERAL STAFF NURSES: 250 bed general hospital and 72 bed maternity hospital. Starting salary $280, $5 per month tenure increase for each 6 months of service to a maximum of $310. Social Security, sick leave, prepaid medical and hospital care. $10 additional for afternoon and night shift, $10 additional for delivery room, $20 additional for surgery. Up to 3 weeks vacation at end of 4 years. 7 paid holidays, 8 hr. day, 40 hr. week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GRADUATE NURSES: Two, and one female laboratory technician. If interested, contact the Medical Director, Florida State Hospital, Arcadia, Fla.

GRADUATE NURSES: Salary range $3400-$3900. including meals and laundry. 3 weeks paid vacation, 12 paid holidays, sick leave and pension benefits. $100 increment granted yearly. Educational opportunities in immediate vicinity. Hourly nurses at $1.50 per hour. Apply Director of Nurses, Newark City Hospital, 116 Fairmount Ave., Newark 7, N.J.

GRADUATE NURSES: 70 bed general hospital, general duty. $215 a mo., $10 extra for eves., nights and relief. Scrub nurses $225, $2.50 per call case. 6 mos. increases for 18 mos., merit thereafter. Full maintenance available. 24 days paid vacation the 1st year, 32 days thereafter. One day per mo. sick leave, cumulative to 45 days. 44 hr. week. Apply Director of Nursing, Mahaska Hospital, Oskaloosa, Iowa.

[Turn the page]

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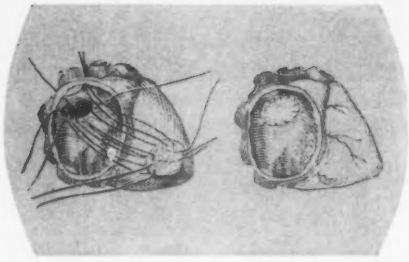
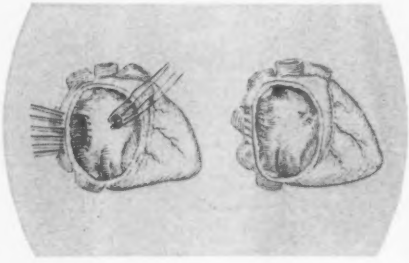


Method of closure of large septal defect while working through an open atrial well. Left shows nylon sheet cut to approximate size and threaded with silk sutures run through the rim of the septal defect. Right shows plastic plate anchored in place and completely covering the defect.

Method of approach to interauricular septum: A rubber "well" is sewed with interrupted silk sutures to the right auricular wall, the wall is opened and blood rises in the well; through this column of blood the hand and fingers are inserted into the right auricle, and the finger can explore the edges of the septal defect.



Method of closure when opening of septal defects are not too wide. Left shows two interauricular septal holes with sutures in place by working through an "atrial well." Right shows sutures drawn tight to close both septal openings.

*A Method for Surgical Closure of Interauricular Septal Defects. Robert F. Gross, M.D., F.A.C.S., Elton Watkins, Jr., M.D., Alfred A. Pomeranz, M.D., and Edward I. Goldsmith, M.D., Surgery, Gynecology and Obstetrics—January, 1953 Vol. 96, 1-23. Surgical Closure of Interauricular Septal Defects, Jl. A. M. A., March 7, 1953.

GRADUATE, PSYCHIATRIC & SURGICAL NURSES: Positions available. Salary $295 to $358. Civil Service Benefits. Apply Superintendent of Nurses, Napa State Hospital, Imola, Calif.

GRADUATE STAFF NURSES: Two. Medical and Surgical Units, floor of 20 beds. Opportunity for young graduates who like to work in Medical Teaching Center in a sociable college town. Apply Director of Nurses, University Hospital, 42nd and Dewey Ave., Omaha, Neb.

MALE NURSES: (a) Supt. of nurses, head and staff nurses, 100 bed hosp. Med. & Surg. cases only. MW. RN1-6 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

MALE R.N.: To work in doctor's office. Salary open. Contact G. B. Pimentel, M.D., Los Banos Emergency Hospital, 925 Pacheco Highway, Los Banos, Calif.

NURSE ANESTHETIST: General Hospital, 700 beds, starting salary $4000 per annum, maximum $4500 per annum. Vacation and sick time. Full maintenance provided. Contact Dr. A. G. Chmelnik, Dir., Dept. of Anesthesia, City Hospital, 116 Fairmount Ave., Newark, N.J.

NURSE ANESTHETIST: 86 bed hospital. Salary open. No O.B. calls. Liberal employee benefits. Apply Superintendent, Group Health Hospital, 201 Sixteenth Ave., North, Seattle 2, Wash.

NURSE ANESTHETIST: Approved hospital, convenient transportation. Salary open. Apply Administrator, Hospital of St. Anthony de Padua, 2875 West 19th St., Chicago, Ill.

NURSE ANESTHETIST: 200 bed general hospital. Salary open, plus benefits. Staff of 3 anesthesiologists and 2 nurse anesthetists. Apply Chief of Anesthesiology, French Hospital, San Francisco, Calif.

NURSE ANESTHETIST: 300 bed hospital near Pittsburgh. Average 40 hrs. per week. Starting salary excellent with yearly increase. Fine working conditions. Write details of training and experience to Administrator, Butler County Memorial Hospital, Butler, Pa.

NURSE ANESTHETIST: 43 bed hospital Northern Florida. Must be willing to take call. Please state salary requirements. Pleasant climate and living conditions. Apply Administrator, Suwannee County Hospital, Live Oak, Fla.

NURSE ANESTHETISTS: 600 bed modern general hospital. 13 air-conditioned operating rooms. $400 salary for experienced anesthetist. Paid month vacation, sick leave and holidays. Contact Director of the Department of Anesthesiology, Sacred Heart Hospital, Spokane 9, Wash.

NURSES: School for cerebral palsied children needs several nurses, 30 to 45 years of age, with mature judgment, for general duty. 8 hr. day, 6 day week, rotating shifts. Salary $250 per mo. with regular increases for satisfactory services. Location 15 miles north of Baltimore. Write or 'phone Miss Verna Mae Brandt, R.N., Supervisor of Nurses, Children's Rehabilitation Institute, Cockeysville, Md. Phone Cockeysville 230.

NURSES: Registered, for positions in modern 115 bed community hospital in Greater Washington (D.C.) area. 40 hr. week, bonus for evening and night duty. Maintenance if desired. Apply Director of Nurses, Suburban Hospital, Bethesda, Md.

NURSES: General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hosiptal, Tuxedo Park, N.Y.

NURSES, REGISTERED: Staff positions. Liberal personnel policies, 40 hr. week. Salary $2912-$3328, regular increments. Day Nursery for nurses' children. Fully approved, college affiliation. Near New York and accredited universities. St. Barnabas Hospital, 685 High St., Newark, N.J.

NURSING ARTS INSTRUCTOR: 300 bed, non-profit hospital located in beautiful seaport southern city, 20 minutes to the beach. Population 50,000. Attractive salary and full maintenance. Straight 8 hr. day, 44 hr. week, liberal vacation and sick leave. For information write Director of Nurses, James Walker Memorial Hospital, Wilmington, N.C.

OPERATING ROOM NURSES: For 200 bed hospital. New and modern surgery. Good working conditions with 44 hr. week. Apply Director of Nurses, Chambersburg Hospital, Chambersburg, Pa.

PUBLIC HEALTH: (a) Nursing consultant, Pac. Coast. (b) Visiting nurse, coll. town, New England. (c) Dir. PH nursing, city-county dept. Calif. RN1-7 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

PUBLIC HEALTH NURSE: In small community. 40 hour week. Car provided. Salary open. Jamestown Visiting Nursing Association, Narragansett Ave., Jamestown, R.I.

PUBLIC HEALTH NURSES: Vacancies in New York City Department of Health. Immediate appointment on provisional basis. Generalized service includes maternal and child care, school health and communicable disease control. Starting salary $2930, 37 hr. week, liberal vacation and sick time allowances, pension rights, in-service training. Applicants (except New York State Veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth St., New York 13, N.Y.

PSYCHIATRIC NURSES: Supervisory and Staff positions open in private psychiatric and fully accredited hospital near Baltimore, Md. Staff nurses begin at $230 a month with periodic increases. Openings also at higher levels. Night duty differential, 4 weeks vacation and 7 holidays with pay, maintenance available at minimal cost. For further details write to Director of Nurses, The Sheppard and Enoch Pratt Hospital, Towson 4, Md.

[Turn the page]

PSYCHIATRIC STAFF NURSE: For a private psychoanalytically oriented 70 bed hospital. Psychiatric experience preferred, in-service program, 18 working days vacation, 15 working days sick leave, evening and night differential. Covered by Social Security, pension plan. Beginning salary $300. Apply to Mr. Basil Cole, Personnel Director, The Menninger Foundation, Topeka, Kans.

REGISTERED DIETITION: $375 per month. Laundry furnished. Qualified to teach student nurses. 40 hr. week. Excellent working conditions. Administrator, Leila Hospital, Battle Creek, Mich.

REGISTERED LABORATORY TECHNICIAN: Good recommendations. 5 day week, 8 hr. day. Salary beginning $325 to $350 per mo. Two positions available at once. General hospital, 200 beds. Reply P.O. Box 840, Battle Creek, Mich.

REGISTERED NURSE ANESTHETIST: Starting salary $365. Automatic increases. Laundry of uniforms, 40 hr. week, no obstetrics. Liberal vacation and personnel policy. Sutter Hospital, Sacramento, Calif.

REGISTERED NURSE: 3-11 Supervisor. Modern 40 bed hospital located 80 miles from K.C. 48 hr. wk. No rotating shifts. Social Security, 2 weeks vacation, meals while on duty. Good working conditions. Salary $250. Supt. of Nurses, Wetzel Osteopathic Hospital, Clinton, Mo.

REGISTERED NURSE: Who is also a laboratory technician. 14 bed hospital in mountain resort. State salary wanted. Ruidoso-Hondo Valley General Hospital, Ruidoso, N.M.

REGISTERED NURSE: For general duty, 24 bed hospital, excellent salary, 2 weeks vacation, sick leave. Living accommodations available. Apply L. L. Deskin, Business Manager, Karnes County Hospital Association, Karnes City, Tex.

REGISTERED NURSES: Medical, Surgical and Obstetrical. 40 hr. wk. $250 to $275 per mo. 60 bed hospital, town of 15,000, Central Ohio. Box 433, c/o R.N. Magazine, Rutherford, N.J.

REGISTERED NURSES: In progressive 250 bed fully approved hospital, located in beautiful, exciting western city with ideal climate, mild winters. 5 day week, 40 hrs., starting salary $3180 per year with increases of $100 per year for each 6 month period up to 3 years. Benefits include paid vacations, sick leave, holidays, hospital insurance, free laundry of uniforms and nursery for children of employees at cost of $1.00 per working shift. Surgery nurses paid on hourly scale starting with $1.65 per hr. with increases every 6 mos. to a maximum of $2.03 per hr. Hourly rate includes allowance for vacations, sick leave, and holidays. Write Superintendent of Nurses, Washoe Medical Center, Reno, Nev.

REGISTERED NURSES: All services, salaries $250, extras—evening or night, $20, operating room $30. 40 hr. week, Social Security and Retirement Insurance, all-graduate staff, 140 bed general approved hospital.

Beautiful new nurses residence. City over 61,000, many cultural and educational advantages. Apply Director of Nurses, Fort Hamilton Hospital, Hamilton, Ohio.

STAFF NURSE: Positions open, liberal policies. Will soon occupy beautiful new 600 bed hospital. Opportunity for advanced study in Nursing, Miami Valley Hospital, Dayton 9, Ohio

STAFF NURSES: Registered or eligible for registration in New York State. Starting salary $250 a month. Increase of $120 a year for two years. A bonus of $10 per month is given for operating room duty and night duty, $20 for 3-11 shift. Insurance, Social Security, 7 holidays, 4 weeks vacation after one year, 40 hr. week, laundry, sick time, living accommodations available at $22.50 for a double room, $30 for a single room, meals available at 33 1/3c per meal. Apply to Superintendent of Nurses, 218 Second Ave., New York, N.Y.

STAFF NURSES: New 25 bed hospital. Salary $275 with 3 meals and laundry. New nurses' home available for $15 a month. 2 weeks vacation, 12 day sick leave with pay, 40 hr. work week. Nurses' home in walking distance of newly constructed swimming pool. For more information about town and position write to Supt. of Nurses, Memorial Hospital, Ft. Stockton, Tex.

STAFF NURSES: Wide clinical experience. 40 hr. week, starting salary $280 a month. For further details please write to Department of Nursing, University Hospital, Ann Arbor, Mich.

STAFF NURSES: For 225 bed southern California general hospital. 40 hr. wk., salary range $245-275. Paid vacation, sick leave. Housing available at $10 month. Apply Personnel Director, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

STAFF NURSES: Come to Houston, golden city of opportunity! Enjoy your winters in the Southwest! Anderson Hospital has vacancies in its new 310 bed hospital located in the heart of the Texas Medical Center. Starting salary $2880 per year with excellent opportunities for promotion to supervisory positions. Additional pay for evening and night duty with no rotation of shifts. Benefits include liberal vacation plan, 40 hr. work week, retirement plan, credit union, life and hospital insurance, and uniform laundry. For further information write Personnel Manager, The University of Texas, M.D. Anderson Hospital, The Texas Medical Center, Houston, Tex.

STAFF NURSES: For new 200 bed approved general hospital in residential suburb of Cleveland. Private rooms available in new residence on scenic site at shore of Lake Erie. New "Square" hospital contains every known convenience for pleasant and efficient nursing. Starting monthly salary, $243 or $251 depending on experience; evening and night, $256 or $264. Increases at 3-6-12-18 months. Team assignment plan, non-rotating. Apply Director of Nursing, Euclid-Glenville Hospital, Euclid 19, Ohio. [Turn the page]

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STAFF & SURGICAL: (a) Staff. Fairly lge. hosp. yr.-round resort, Fla. (b) Surgical, Costa Rica. (c) New hosp. foreign operations, Amer. Co. $350 living allowance, $220. (d) Staff & surg. Gen'l 200 bed hosp. affil. leading clinic. Univ. center, So. RN1-8 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SUPERVISORS: (a) O.R. To develop new 400 bed hosp. teach'g center in foreign country sponsored by wealth Amer. Foundation. City 350,000, Far East, mild tropical climate. Lge. American colony. $6800 plus $1000 for transportation of goods plus all travel. exp. Very interesting assignment. (b) O.R. Teaching hosp., 600 beds, finest facilities, med. sch. affiliated. Req's superior person, large city, several med. schools, MW. (c) O.R. One w/special trn'g & exper. Vol. gen'l hosp. 200 beds. Very adequate number grad. staff to assist. Excel. school. Lovely res. town 25,000 few miles to lge. city, important univ. med. center, E. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

SUPERVISORS: (a) Operating room and central sterilizing room. New 400 bed hosp. under Amer. auspices, Asia. $5000. (b) Ped. Fairly lge. hosp. Calif. $300-$375. (c) OR, neurosurg. med., psy. & thoracic surg. New hosp. unit univ. group. Lge. city, med. center. (d) Thoracic surg., new dept., 400 bed hosp. affil. univ. educational oppor., E. (e) Medical, new unit univ. group, MW. $360-$495. (f) Ob and evening, gen'l 275 bed hosp. Res. town near 2 univ. centers, E. (g) Central supply, new dept., small hosp, Coast town, Calif. (h) Chief, operating room, new 350 bed hosp. Affil. important clinic. Coll. town, E. Min. $5000. RN1-9 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SURGICAL NURSES: For 165 bed hospital in residential suburb of Chicago. 40 hr. duty after September 1, 1953. Cash salary $230. Full maintenance in addition to salary includes single room in new nurse's residence plus meals and laundry, which is equivalent to $350 per mo. Low rental apartments for married nurses, and $25 additional salary rate for nurses living in their own homes. $10 increase after 60 days and at regular intervals. Two to four weeks vacation, 6 holidays, sick time policy, free life insurance, Blue Cross Hospitalization available. Remuneration for call. Leave of absence with full salary for post-graduate experience. Write Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

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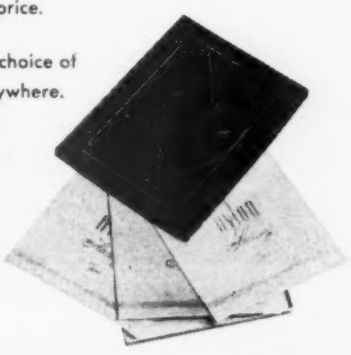

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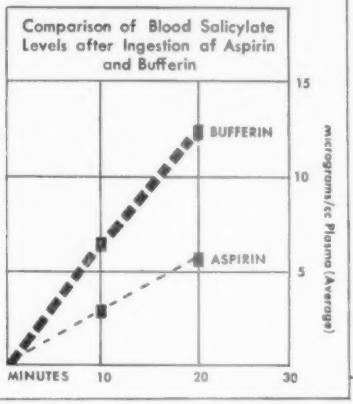

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1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid. J. Am. Pharm. Assoc., Sc. Ed. 39:21, Jan. 1950

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